Aging in Place:

The Demographics and Service Needs of Elders in Urban Public Housing

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In addition to her substantitive involvement in research design and data collection, Faith Waltman took particular responsibility for Chapter 5. The research into PHA programs and projects and the resulting descriptions are her work.

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1.0 INTRODUCTION

1.1 Aging in Place: The Problem and the Prospect

The term "aging in place" occurs with increasing frequency in discussions of issues relating to elders. To managers and administrators of public and subsidized housing, the term refers to people getting older. This complicates the role and responsibility of managers. Most subsidized elderly housing was built ten to twenty years ago. The initial residents tended to be "younger elderly"--people in their mid-sixties. In many developments, a whole group of residents moved in at the same time. Twenty years later, those original residents still make up the majority in many developments, but now they are twenty years older, and increasing age has brought with it increasing frailty. Managers who initially dealt with healthy and independent tenants now find themselves called upon to deal with more problems, more crises, more illness.

There is also a second meaning to the term "aging in place". To elder persons, these words imply not a problem but a challenge and an opportunity--the opportunity to live independently and to avoid institutionalization as long as possible. There are circumstances, of course, in which hospitalization or nursing home care is appropriate. Too often these institutions are needed, however, in a situation of temporary crisis or illness because nothing more workable is available. Ideally, it might be more appropriate to offer services which let the resident cope with daily life in his or her current home. Such services can often be far less expensive, to the person or the taxpayers, than hospitals or nursing home. Yet if services cannot be obtained, elders who badly want to stay in the place they call home, and who are quite capable of

doing so with some help, may be forced to move to an institution.

1.2 Public Housing Agencies (PHAs) and Services

These implications of "aging in place" are reflected in the points of view that come together in public and other subsidized housing for elders: that of the resident and that of the manager. Managers--already responsible for physical maintenance of buildings, tenant relations, rent collections, controlling utility costs, supervising maintenance and security personnel, and other management tasks--are faced with difficult choices. Perhaps an elderly resident has fallen and broken her hip, perhaps; another appears to be alcoholic; another forgets to take medication unless reminded, and becomes emotionally unstable when he forgets. The manager probably has had no training for dealing with such problems, no staff with this training, and no budget for providing services. There may be services available in the community--but does the resident know about them and how to arrange them? If not, can the manager or another staff member do this for the resident? For how many residents? If the manager cannot help, what then? Should the resident be transferred to a nursing home or hospital? What if the resident refuses and has no family who can or will intervene? What are the legal implications for the housing authority? At what point does eviction become the only recourse? How soon will a manager "burn out", faced with such choices?

To the resident, the manager may be seen primarily as a landlord, not a potential caretaker. The resident may feel it is necessary to hide problems from the manager and other staff, not

only as a matter of personal pride, but also (and often realistically) to avoid the risk of eviction. At the same time, the resident may have no one else to turn to, no contacts with potential service providers, no family to assist.

There are third parties whose perspectives are also relevant--the service providers. Presumably, there are agencies in the community such as a Council on Aging, a homemaker or home care agency, a Visiting Nurse Association, or a Meals on Wheels program. Do these agencies have any ongoing contact with the housing authority? Do they think of "public housing" as a place where many needy clients live, or as a place that is dangerous and unpleasant to go into, or both? Do they conduct outreach in the developments? Are their procedures more geared to <u>individual</u> clients, so that they cannot take advantage of potential "economies of scale" in a group living situation? Do the services they can provide match the needs of the elder residents in the housing developments?

One solution to some problems may be a joint project between the housing authority (PHA) and service provider agencies. Many such projects will be discussed in this report. It may not be easy to implement such a project, however. <u>A major problem is the source of funding</u>. PHAs generally receive funding to provide services. HUD does not furnish such funding, and, except in a few cases, states do not either. (In Massachusetts, predictable funding has been available in recent years for services in elderly congregate housing as a result of cooperation between the state's Executive Office of Elder Affairs and the Executive Office of Communities and Development. Comparable funding is not available in conventional elderly housing, however, or for elder residents in family develop-

ments.) Funding for services usually depends on special grants. This has many implications: proposals for funds must be renewed periodically, usually yearly. This is time-consuming, and there is no assurance that proposals will be funded or re-funded. Staff continuity cannot be assured if funding is not predictable. Further, the PHA has to apply for funds which are available according to the priorities of the grantmakers, and these may not match their residents' most pressing needs. Service providers are often oriented toward services for individual clients, and may resist making commitments to projects which treat public housing tenants as groups. Such circumstances reduce a PHA's ability to address the service needs of its elder residents rationally.

This report will not answer all the questions that have been raised in this introduction. Many of them can only be answered in individual cases. The report <u>will</u>, however, address many such questions, and the answers it provides should be useful to those who must grapple with the problems associated with aging in place. We will examine data about the elderly residents of large urban public housing developments. We will examine some characteristics of the housing developments they live in. We will look at housing authority policies about admitting elder applicants and retaining current residents. We will also examine the services that are currently available to these elders, or that might be offered to them. Who provides these services? How extensively are they used? What are the greatest unmet needs? Why do gaps exist?

The following sections provide a further description of the report which follows--why the study was undertaken, how it was

carried out, and how the report itself is organized.

1.3 Need for Data on Elders in Public Housing

Despite increased attention in recent years to elders and issues which impact them, little is known about senior citizens in the nation's public housing. HUD has some data on designated elderly and handicapped housing, but this tends to be unreliable in various ways such as distinguishing between elderly and handicapped, adjusting for vacant units, and so forth. Moreover, "elderly" generally means anyone over 62 years of age, leaving no way to distinguish between "older and younger elders." Aggregate data also tend to be at the PHA level, and thus tell nothing about various individual housing developments.

Further, elders do not necessarily live in "elderly housing." Many live in family developments, often in units they have occupied for years or even decades, from which their children and other family members have now gone. Many PHAs do not have data about these elders. Even at the local level, administrators and managers may not know how many such residents they house, what kinds of households they live in, or what their service needs are.

If the service needs of elders in public housing are to be assessed in a reasonable manner, the first priority is to determine how many such residents there are and what they are like. How elderly are they? What are their races? Their incomes? Where do they live? Do they live in families or alone? This study addresses these questions with information obtained from a survey of PHA administrators, development managers, and service providers. The next subsection gives more details about the study's design and

data collection.

In order to discuss elder service needs in public housing, our survey also sought to learn much more about services that are currently being offered: what are they? how widely are they offered? how extensively are they used? what are the greatest unmet needs?

Finally, it is useful to examine ways in which some practitioners are addressing the problems uncovered by the study. PHA administrators, managers, and services staff are usually well aware that the problems exist, and many are attempting to solve them in various ways. Our survey examined these "emerging practices" and found a wide variety of them. They range from limited special-purpose programs to comprehensive ones. Some are planned and provided directly by the housing authorities. Others are joint undertakings with service agencies, subcontracted to service agencies, or simply provided independently by these agencies in space made available free or at low cost in PHA buildings. Examples of such programs, including information on why they were developed and how they are funded, will also be described in this report.

1.4 Data and Data Collection

The study was designed to gather data from large PHAs--that is, those with 1250 or more units. There are 133 such PHAs, located primarily in urban areas across the country. After telephone contact, an initial survey was sent to the executive director of each PHA, with a request that it be completed and returned by mail. The directors were very cooperative and very interested in the findings

they hoped would result from this study. If the survey was not returned within the three-week time period we requested, follow-up calls were made to the executive director to learn about any problems and to encourage response. We received responses from 100 of the 133 PHAs, a 75 percent response rate.

We then randomly selected PHAs in 25 cities from among the 100 responses. Two developments were chosen from each of these 25 PHAs, again at random. The "pool" from which developments were sampled included conventional elderly developments, family developments with large concentrations of elderly residents, and congregate elderly developments. Executive directors were contacted and they supplied us with the names of the site managers of the 50 sample developments. We also attempted to obtain names of service providers with some knowledge of the developments in question. This proved to be easy in some cases, but very difficult in others. Beginning at the central office of the PHA, we asked executive directors and services staff for the names of such service providers, or of agencies with some contact with the development. If no leads could be obtained at the central level, we asked the manager the same questions. If all else failed, we called elder service agencies directly to find someone who was familiar with the development in our sample.

Managers and service providers were contacted by telephone, familiarized with the study, and asked to complete a second survey. The potential respondents we spoke with were also very cooperative. However, we were unable to locate service providers who were familiar with some developments in the sample. Questionnaires were

again mailed to the persons whose names and addressed we obtained. If no response was received within three weeks, we called the potential respondent to encourage him or her to complete the instrument and mail it to us. Of the fifty managers contacted, 39 (78 percent) returned completed questionnaires; but service provider responses were obtained for only 24 of the 50 developments (48 percent). As noted, this was usually because we did not find a service provider who felt qualified to discuss the development. This is more than a surveying problem, of course; it is also an important indicator that, for as many as half our sample developments, managers could not name any regular service presence, either from PHA staff or from an outside agency.

The central-level survey was designed with two primary goals in mind. First, we wanted to get as accurate a count as possible of the number of elder residents served by the PHAs, together with information about their location and demographics. Secondly, we wanted data about authority-wide policies, practices, and perceptions with regard to elder residents and their service needs. The instrument contained four sections:

- Elderly Developments and Units
- Elderly Tenants in Non-Elderly Developments
- Demographic, Income, and Household Characteristics
- Policies on Admission, Service Provision, and Relocation

Questions on services dealt with all developments, sometimes breaking out three subcategories: (1) conventional elderly and handicapped developments, (2) conventional family developments, and (3) congregate facilities. Respondents were encouraged to note projects or policies of interest at particular developments, but detailed questions about services at the development level were

reserved for the second instrument. A full copy of the instrument is found in Appendix A.

The development-level survey was completed, where possible, both by the site manager and by a service provider familiar with the development. This provider might be either a representative of a community agency or a service specialist employed by the PHA. The manager was asked to complete all four sections of the instrument, the service provider only the last section:

- Development Characteristics
- Elder Households and Individuals (Income and Demographics)
- Admission and Retention
- Services and Service Needs

A full copy of this instrument is found in Appendix B.

In order to enrich the data available at the development level, PHA responses to the first instrument and other agency documents were reviewed to find any projects of special interest that might be taking place. The developments involved in these projects were listed out. When the sample for the second instrument was selected, the developments in that sample were reviewed to determine whether these "particularly interesting" developments had been captured by the sampling procedure. If they had not been included, we selected them into a special category for the second survey. Within this category, managers and service providers were located, called, and mailed questionnaires, as happened with the sample developments. Because this group had been selected nonrandomly, however, their responses were not computerized for inclusion in quantitative analyses. Instead, the questionnaires were kept separate for use in qualitative and descriptive analysis. Responses were obtained from an additional __ developments in this category.

1.5 Data Receipt, Entry and Cleaning

As questionnaires were returned, they were logged in and checked for completeness and face validity. If some questions had been left blank or if answers were confusing or contradictory, respondents were contacted by telephone to clarify or complete the answers, if possible. In many cases it was impossible to resolve internal contradictions because some PHAs' records were different from those of other authorities, and/or different from the categories in which we had asked the questions. (While we were designing the instruments, we had contacted eight PHAs in various parts of the country to learn whether they had the records we wanted and how their data was organized, maintained, and grouped. This survey showed that most PHAs did keep the information in which we were interested, but that there was little consistency in how it appeared in their records. Both the positive and the negative conclusions of this preliminary "scan" proved accurate in the survey itself.)

For example, most information we requested was about elder heads of household--a category that PHAs use for many items which they must report to HUD. Some responses, however, were clearly for all elderly individuals, whether or not they were heads of household. But the respondents rarely noted which basis they used for their answer. Indeed, they often did not know themselves. They were simply transfering numbers that appeared in a report or computer printout they had been given.

Similarly, some PHAs have records only for residents of elderly and handicapped housing, but not for elder residents in family housing. Here again, they tended to give us the data they had

without warning us that the basis was different from the one in our question. Contradictions of this type were usually clearly visible when answers were compared within a questionnaire. In many cases, a telephone call clarified the situation. Sometimes different data were available, but the more usual outcome of the telephone call was to help us understand the answers we already had. That is, most PHAs did not have the more comprehensive data and could not have obtained it without expensive and time-consuming efforts. The analytic chapters of this report describe data problems relating to particular questions, and note any findings that might be affected by them.

When answers had been clarified as much as possible, closed-ended responses were entered into a computer for analysis. Open-ended responses were listed out individually and, where groupings were apparent, postcoded into response categories and computerized. Open-ended responses and descriptive materials sent us by the PHAs, together with questionnaires and materials from the nonrandomly chosen group of developments were subjected to qualitative analysis. In particular, we searched for patterns in responses relating to policies, procedures, emerging practices, training, need assessment, and service delivery. These materials are especially helpful in interpreting PHA intent--e.g., how they see their role vis-a-vis their tenants and what they want to accomplish by the things they are doing or planning to do.

The report thus draws from a data base which is essentially quantitative--the survey responses--but which also includes some of the richness only obtainable from qualitative data.

1.6 Overview of the Report

Four analytic chapters follow this chapter of introduction and methodology. Chapter 2 examines data on number of developments and units, numbers of households, residence in elderly or family developments, and income and demographic data. It also includes data on why elder residents left public housing units. Chapter 3 discusses PHA policies, procedures, and problems, particularly policies related to admission, retention, and service delivery. Chapter 4 presents an examination of services--what is provided, who provides it, and perceived gaps and unmet needs. Chapter 5 discusses ways in which PHAs are attempting to fill gaps that exist, both through their own efforts and through cooperative projects with other agencies. Finally, Chapter 6 presents a summary of findings, conclusions, and recommendations of the study.

2.0 PHAs AND THEIR ELDER RESIDENTS

Overview

This chapter examines data on developments managed by the responding PHAs, especially on elderly and congregate developments, and on the elder residents who live in them. The initial section discusses numbers, sizes, ages, and bedroom mix of developments. Subsequent sections turn to elderly households and examine numbers, location in elderly or family developments, and demographics. The final section presents "exit data" on elder residents who have left public housing developments.

2.1 Elderly Developments and Housing Units

In all, 100 PHAs responded to the questionnaire. Two of these were able to furnish only limited data and thus have been dropped from most analyses. The remaining 98 manage a total of 1,236 elderly developments (most including some handicapped units), and at least 1,814 family developments. There were also 16 congregate developments reported. It should be noted that the term "congregate" is not used consistently among PHAs, and therefore is also inconsistent in this report. In some areas, such as Massachusetts, "congregate" refers to developments which have been built or renovated for group living; such developments often have shared facilities such as kitchens, dining rooms, bathrooms, or visiting/sitting rooms. In much of the country, however, "congregate" is used to designate developments which participate in HUD's Congregate Housing Services Program (CHSP). Under this program HUD supplies funding to provide some congregate services--usually some group

meals--in otherwise conventional elderly and handicapped developments. This is discussed at more length in Chapter 5 of this report.

There were 115,615 units in elderly developments, 442,103 units in family developments, and approximately 637 congregate units among these developments. (It should also be noted that some PHAs were not able to separate out handicapped units from elderly; the figure for elderly units is therefore something of an overcount.) Occupancy rates were about 97 percent for elderly, 94 percent for family, and 91 percent for congregate. The congregate figure is lowered by a development that was only partly rented up at the time of the survey.

Age of Elderly Developments

As noted in the introduction, a development's age may be closely related to the average age of its residents. In many cases, original tenants were mostly in their 60s. Those who remained in residence, of course, have grown older. Thus, a building that is ten years old many have a disproportionate number of residents in their 70s, and a building twenty years old man have many residents in their 80s.

Figure 2-1 shows the distribution of age of elderly and handicapped developments across four categories included in the central-level questionnaire. It also shows graphically the influence of federal housing policy: about two-thirds of all developments were built between 11 and 25 years ago--that is between 1960 and 1974. Only about three percent were built before 1960; only about 15 percent have been built in the last five years. It also appears

Figure 2-1: Age of Elderly Developments
(in percents)

that the developments built recently have tended to be smaller than those built earlier. Figure 2-2 shows the distribution of units by age of development. As one would expect, it is very similar to Figure 2-1. However, it shows that an even higher proportion of units than developments were built 11 to 25 years ago, and a lower proportion in the last five years.

These figures help to show why "aging in place" has increasingly become a management issue for PHAs, with the attendant increase in service needs shown in later chapters of this report.

Size of Elderly Developments

Figure 2-3 shows the distribution of development sizes. About half the elderly and handicapped developments had between 51 and 150 units; about one-third had between 151 and 400. Only a handful were larger than 400 units, while about 17 percent had 50 or fewer. As might be expected, congregate developments tended to be smaller. Half of the 16 congregate developments discussed in the survey had less than 30 units, and four had less than 15. Many of the CHSP congregates were much larger, however.

Size of Units in Elderly Developments

As Figure 2-4 shows, most of the units in elderly/handicapped developments are one-bedroom. This implies one separate bedroom in addition to a kitchen, living room, dining room (perhaps combined with the kitchen or living room), and a bath. Slightly over a quarter of the units, however, are zero-bedroom or efficiencies.

Zero-bedroom units are adequate for a healthy elder living alone, although of course they have no sleeping room for visiting relatives or friends. Such units create a problem, however, when a

Figure 2-2: Units by Development Age
(In percents)

Figure 2-3: Size of Elderly Developments(in percents)
(in percents)

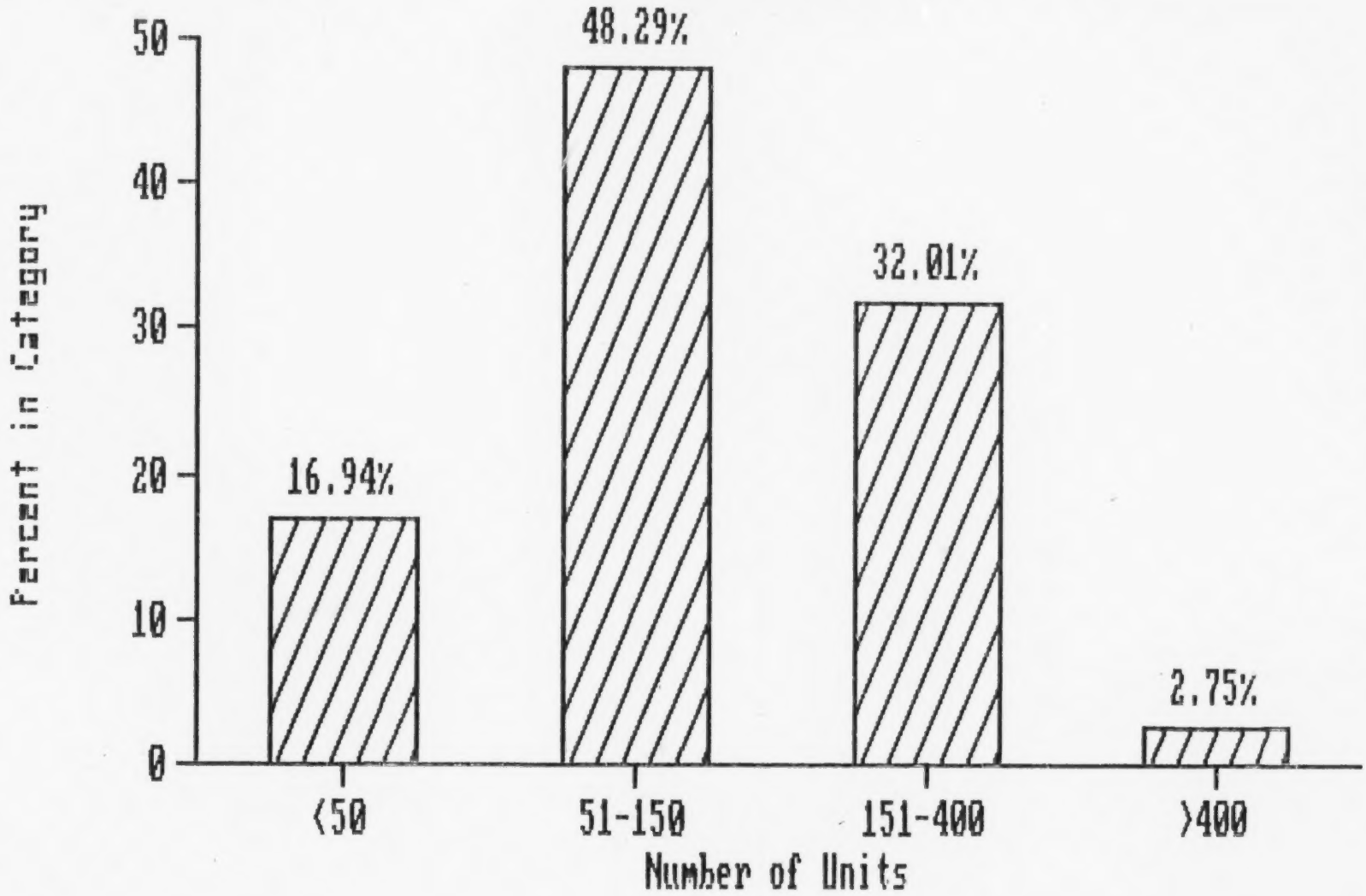
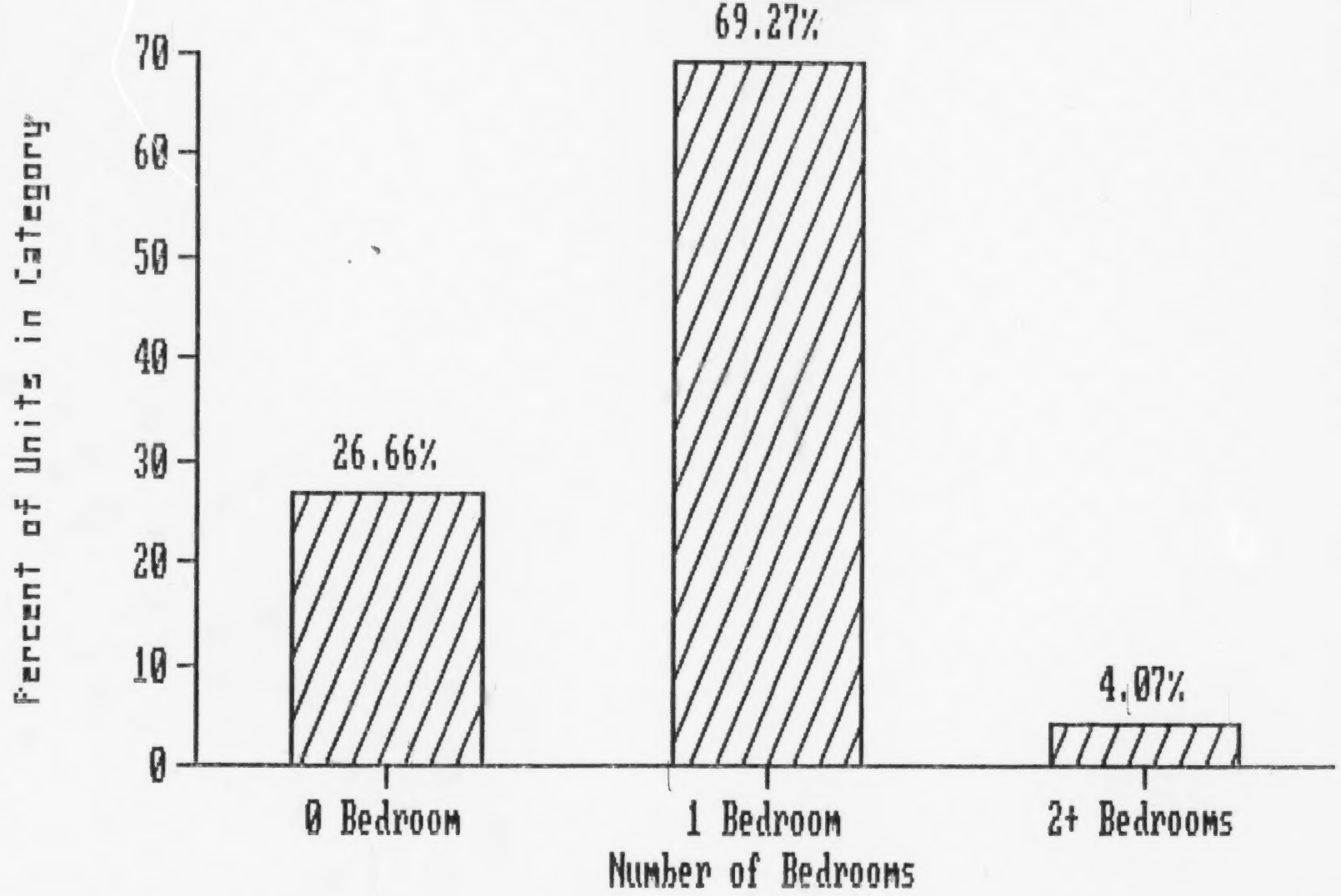


Figure 2-4: Units by Bedroom Size
(in percents)



resident becomes ill or is injured and requires temporary live-in care from a relative, homemaker, or nurse: there is no room for such a helper. This circumstance often forces the resident to move to a care facility, and sometimes forces the PHA to require the elder to vacate permanently, even though temporary at-home care would otherwise be feasible. The result is that the elder person has lost his or her home and been forced into an institutional setting even though he/she might be capable of independent living after a recovery period.

Despite this disadvantage, HUD's construction and rehabilitation standards in recent years have encouraged or required PHAs to build zero-bedroom units, and have discouraged the renovation of zero-bedroom units into more practical sizes. This policy appears to be based on short-sighted cost-containment criteria which overlook the eventual cost to the elderly and to taxpayers who must pay for more expensive institutional care.

2.2 Numbers of Elder Households

How Data Are Presented

Because of the data problems noted in Chapter 1, numbers of households in general and in various subcategories cannot be counted precisely. However, the numbers are in substantial agreement, and relatively accurate estimates can be made.

As noted earlier, our questions were based primarily on numbers of elder-headed households--the most common basis for PHA record-keeping. Some PHAs, however, only maintain data on all elderly individuals; a few only have records for elders who live in elderly housing, but not for those in family developments. It was usually possible to establish which basis a PHA used in completing our questionnaire, but even then it was not possible to convert their answers to our head-of-household categories. Moreover, some PHAs used different categories for different questions--whatever they had on hand.

This potpourri of data leads to a certain amount of confusion, but not to substantive error. Elder households are predominantly single-person (see Section 2.4 below). For this reason, estimates based on all elderly individuals will not differ radically from those based on elder heads of household. Nor is there reason to believe that percentages falling into any demographic or income category will be very different, or different in systematic ways.

This is not the case, however, when data are reported only for residents of elderly housing , but not for residents of family housing. The ethnic makeup of elderly developments, for example, is often quite different from that found in family developments. Household size and characteristics may not be the same. Luckily,

few PHAs reported only elderly development residents, and those that did so made it clear that this was their basis. This has made it possible for us to use those data separately from other data. Analyses are normally done only on data from PHAs which reported on both elderly and family developments. Where appropriate, separate analyses are presented for the eight PHAs which reported only elderly development data.

In order to avoid confusion over the numbers of cases in each analysis, analyses are presented in percentages--e.g., the percentage in each ethnic category or each household size category. The total number of elder-headed households is used as the basis for discussion throughout.

It should be noted that these data problems result from the lack of standardization in PHA record-keeping, and thus are inescapable unless a study can afford to visit each PHA and attempt to impose uniformity on the data it collects. The numbers presented in this report are, to the best of our knowledge, the most comprehensive and accurate that exist anywhere. We are confident that the picture they show is essentially accurate.

Number of Elder-Headed Households

Strenuous efforts were made to determine the best estimate of number of elder-headed households for each PHA. When PHAs did not have records on elders living in family developments, the executive director was asked to estimate the number for us on the basis of

the best data available. Only two of the 100 PHAs were unable or unwilling to give us such an estimate. For those two, we counted only elders living in elderly developments. Thus, our total is something of an underestimate.

A total of 204,080 elderly households were reported by the 100 PHAs responding to our questionnaire. This number will be used as the basis of other analyses and discussions in this report. Across PHAs, this number ranged from a low of 333 to a high of 49,330; the median number was 968 households.

Figures from New York and other PHAs with good records show an average household size of about 1.2. Using this as an approximation, our 204,080 elder-headed households probably represent about 245,000 individuals, most of them elderly.

2.3 Residence in Elderly and Family Developments

Elder residents in elderly/handicapped developments are relatively visible to managers and administrators; they live in buildings which have been designed for use by elderly and handicapped persons; and they live in buildings and developments which, for the most part, are occupied only by households of these types. (There are, of course, mixed elderly and family developments. Most such developments tend to have separate buildings--or parts of buildings with separate access--for elders.) Elders living in family developments, however, may be less noticeable to managers faced with the range of problems which often accompany housing families. They may live in buildings which are not adapted for elder residents--e.g., with handrails, wheelchair access, emergency call buttons, and the like. And, since they live among families, they will be exposed to

both the good and bad aspects of life in an intergenerational development.

The numbers of elder residents in elderly/handicapped public housing are relatively well known, since these households are broken out in reports to HUD. The numbers of elders living in family developments, however, are largely unknown. Many PHAs do not know themselves how many such households or individuals they serve. Our questionnaires asked administrators and managers to give us separate counts of elder households and individuals in elderly and family developments, or, if counts were unavailable, to give us their best estimates.

Our data showed 48.6 percent of elder households lived in elderly/handicapped developments, with 51.4 percent in family developments. Applied to our total number of elder households, this implies that about 105,000 households live in family housing in these large urban PHAs, with about 99,000 in elderly developments. The majority of elderly households in public housing, then, appear to be in family developments.

This number may be influenced by PHA record-keeping to some extent. Our questions asked about elder residents in "elderly and congregate developments" and in "family developments". Some PHAs may have included elders living in mixed developments with separate elderly units in the "family development" count. These residents typically occupy units designed for the elderly--with handrails, emergency buttons, and the like--although the units are located within a family development.

Fortunately for analysis purposes, a large percentage of these

households live in New York City, which has very good statistics on residence by type of development. In fact, of the approximately 105,000 elder households in family developments, about 42,300 are in New York City. Many of these, however, are in developments with units especially designed for the elderly. New York has approximately 19,000 units specially designed for the elderly. Of these, something over 7,000 are in exclusively elderly developments. This leaves about 12,000 such units in predominantly family developments. Doubtless some of these units are vacant and others are occupied by nonelderly handicapped people or other households. Nevertheless, the figure gives us a bounding estimate. Of some 42,300 households in family developments, as many as 12,000 may be in units especially designed for the elderly. This leaves at least 30,300 households in family developments and not in specially designed units.

We thus have three broad types of housing circumstances. First, there are elders who live in predominantly elderly housing. Secondly, there are elders who live in specially designed units located in predominantly family developments. (These are often separate buildings or parts of buildings with separate entrances; design of this type help insulate elders to some extent from the adjacent family development. Some, however, are scattered units that have been built or modified for elders, but are not physically buffered from the family housing around it.) Finally, there are elders who live in family development units with no special design features for elders.

Can we measure the size of these three groups? We have already estimated that there are 99,000 elder households living in elderly

housing developments. What about the remaining 105,000? Data for PHAs other than New York City are not nearly so detailed. However, we can continue to make bounding estimates. If all the non-NYC households in family developments live in specially built elderly units (this is very unlikely), the following estimate would result: 85,000 households in specially designed units and 30,000 in normal family development units. If none of the non-NYC households live in specially designed units (also very unlikely), this estimate results: 12,000 households in specially designed units and 93,000 in normal family development units. If the percentage in the other PHAs is similar to the percentage in New York City, our estimate is 30,000 households in specially designed units and 75,000 in normal family development units. This estimate at least has more credibility than the first two, which make obviously false assumptions.

If we take it as a working figure it would mean that about 48 percent of elder households live in predominantly elderly developments, another 37 percent live in family units in family developments, and the remaining 15 percent live in specially built elderly units located in predominantly family developments. Households in the last category probably live in barrier-free units, which may or may not be located in barrier-free buildings. Their social circumstances probably vary with the size and design of the elderly portion of the development. If the elderly units are in a separate building or part of a building, their life may be very similar to that of elders in elder developments. If the units are "imbedded" in the family development, their life will be more like that of elders living in "normal" units in family developments.

Concentrations of Elder Households in Family Developments

Elderly residents who live in family developments have often lived there for years (See Figure 2-5). In many cases, they lived there with their families until children grew up and moved away. Now they continue to live in couples or, more commonly, alone in family units. There are reports in many cities of family developments which have acquired a sizeable proportion of elderly residents in this way.

We asked PHA administrators to tell us how many, if any, family developments they managed in which more than 25 percent of the resident households were elder-headed. By far the largest number was in New York City, which listed 108 such developments. (New York's list included some family developments with some units built especially for the elderly. If we assume that all these units are actually occupied by elder households, it lets us estimate the number of family developments in which 25 percent or more of the households are elders living in units not built for the elderly. There are 58 such developments in New York City, with elderly percentages ranging as high as 72 percent.) No other city identified more than seven developments in which 25 percent or more of the units were occupied by elder-headed households; however 55 of the 98 PHAs responding to this question listed at least one development in this category.

Selected Amenities in Elderly and Family Developments

Administrators were asked to report the percentage of their units in elderly developments which had each of five amenities or

modifications. They were

- o community space for recreational or educational use
- o community space for provision of services
- o handrails in units (e.g., bathrooms)
- o call buttons in units
- o wheelchair modifications in units.

Table 2-1 shows PHA responses to this question.

Table 2-1
Amenities and Modifications in Elderly Development Units

	Percentage of PHAs in each category...			
	All units have amen.	80-99 percent have amen.	50-80 percent have amen.	Under 50 percent have amen.
Rec./Ed. Space	79.6%	7.1%	5.1%	8.2%
Service Space	72.4	7.1	7.1	13.4
Handrails	61.2	7.1	6.1	25.6
Call Buttons	50.0	9.2	9.2	31.6
Wheelchair mod.	13.3	6.1	5.1	75.5

N=92, Missing Cases=8

Table 2-1 shows that most developments have space available for recreational or educational use, or for services. (The responses do not necessarily mean that the available space is actually used in this manner, however.) A majority have handrails in units, and half have call buttons. Only wheelchair modifications are not found in a majority of units. It should be noted that the question asked about wheelchair modifications within units, not about access to buildings, elevators, and the like. About one-third of the PHAs reported that no units had such wheelchair modifications; another 40 percent reported that 10 percent or less of their units had them.

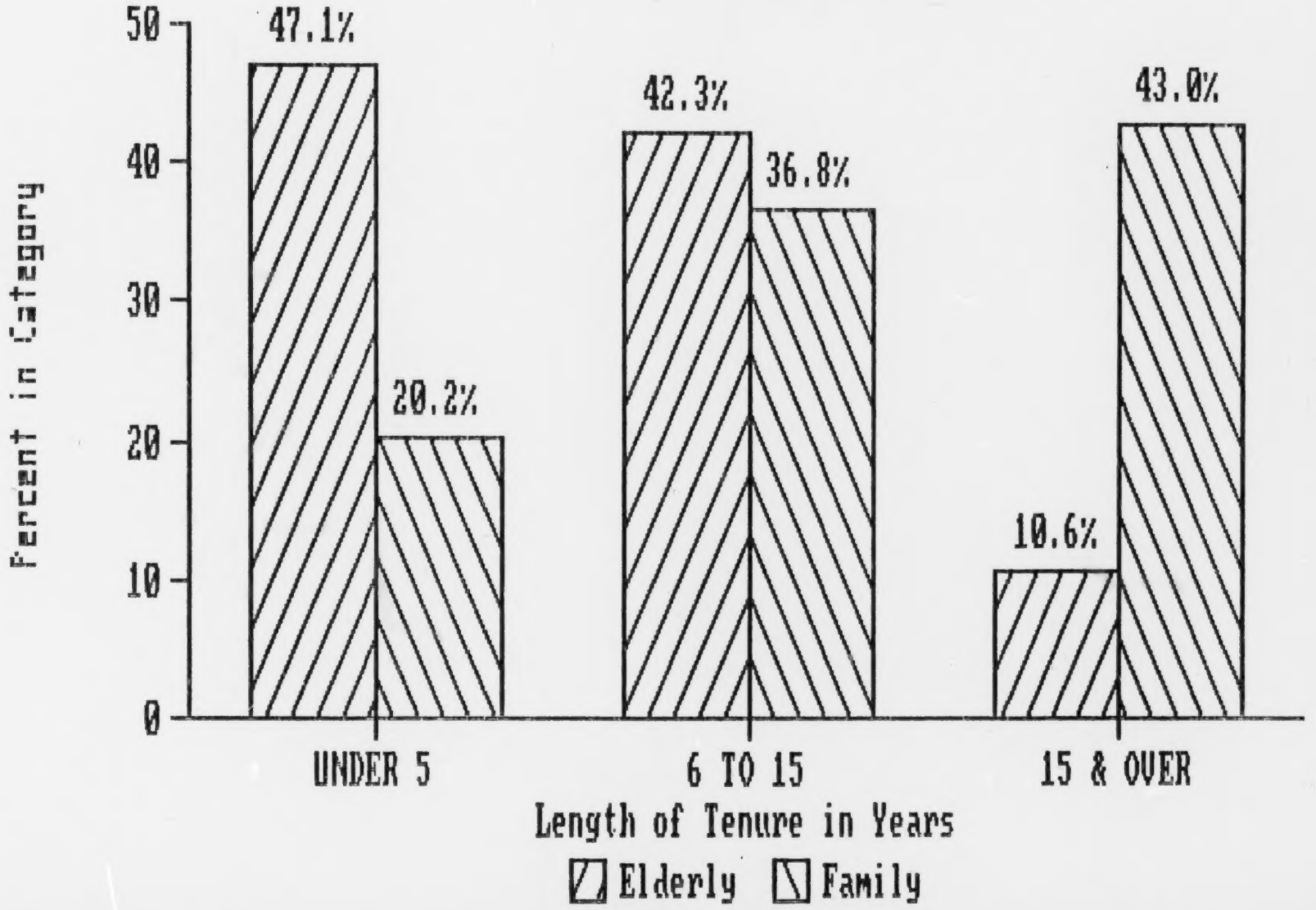
Administrators were also asked how often they made modifications such as those listed above in family units occupied by elderly households. Of the 89 PHAs which answered the question, 4.5 percent said "Always", 18 percent said "Frequently", 62.9 percent said "Seldom", and 14.6 percent said "Never." It is evident from these responses that elder residents in elderly developments generally have most of the listed amenities, and that elder residents in family developments seldom have them. (Residents of elderly units in mixed developments would presumably be an exception in many cases.) Since we have already found that the majority of elders in public housing live in family developments, this implies that a very large number of households lack the adaptations and amenities that we generally assume elders in public housing enjoy.

Length of Tenure

We also asked administrators to tell us how long residents had lived in their current developments. Responses are shown in Figure 2-5, by type of development. The interpretation of the figures depends on the type of development in question. In elderly developments, most residents will have moved in at age 62 or older. Thus, those who have been tenants for 6 years will tend to be at least in their high 60s and those who have been there 15 years or more will be at least in their high 70s. (This is a minimum estimate, of course: elders may not move in until the head of household is at least 62, but he/she may be much older when tenancy begins.)

Figure 2-5 shows that almost half the elders in elderly developments have been in residence less than five years; a slightly

Figure 2-5: Elder's Length of Tenure
(in percents)



smaller percentage have lived there six to 15 years; and 10.6 percent have been tenants for more than 15 years. Some guesses could be made about ages from these figures; since the next section will present data on ages, however, there is no need to engage in guesswork here. It should be noted, however, that over half of all elder residents have been in their developments for six years or more. This is long enough for ties to be formed and for hopes and expectations to develop. It helps explain how a public housing development can come to feel like "home" to an elder resident, and why premature or unnecessary institutionalization can be traumatic. It also helps us understand the desire expressed by many managers to provide services that help prevent such institutionalization--even when a PHA's formal policy expects all tenants to be capable of independent living--and managers' frustration when they cannot provide the needed services. It is inevitable--and it is good--that in many cases the elder becomes more than just another tenant, and that the manager more than a landlord.

Figure 2-5 shows a somewhat different picture for elders living in family developments. A far smaller percentage are recent arrivals; 43 percent have been in residence more than 15 years. This supports the conclusion that many of these elders originally moved to their developments when they were parents of minor children, and have continued to "age in place". To the extent that this is true, they live in developments and units built for families, not for elders. As noted above, such units may lack amenities or safety features usually found in elderly developments. In troubled family developments, elders may be subject to more crime, violence, noise, vandalism, and the like than would be found in elderly develop-

ments. It is equally true, of course, that in better family developments elders may appreciate the presence of younger people and families.

Since tenancy might have begun at almost any age, no conclusions can be drawn as to the probable age of these elders, beyond the fact that they are now 62 or older. Data on age will be examined directly in the following section of this chapter.

2.4 The Demographics of Elders in Public Housing

This section of the report rounds out the picture of elder households in public housing by examining some of their demographic and income characteristics. Data on age, household size and type, ethnicity, income, and source of income will be presented.

Age

Among adults, greater age is inevitably related to a higher incidence of frailty. Some studies of elders in public housing have not found such a relationship (Cf. Stockard and Stockard, 1985), but this does not imply that elders in their sixties are as frail, on the average, as those in their nineties. It simply means that, in general, frail elders cannot continue to live in public housing. Those who become frail must usually move out. Those who remain are the ones who can live independently.

This is precisely the challenge for PHAs and policymakers who want to encourage "aging in place". In order to deal with an older, frailer population, managers and service providers must respond more frequently to situations which have led, in the past, to institutionalization. They must be given resources which help

them avoid this outcome in the future, in cases in which it is inappropriate.

Unfortunately, PHA record-keeping is as unstandardized with regard to age as it is in other respects. PHAs must report to HUD about heads of household in elderly/handicapped housing who are over 62 years of age. They are not required, however, to report on ages of elder residents in any more detail. Thus, most do not keep more detailed records. Some do, however, and our data are based on those PHAs.

A total of 32 PHAs were able to report data in the categories we requested. This includes the New York City Housing Authority, which accounts for almost almost one-quarter of the households in the study. Given the smaller number of PHAs in this analysis, NYC households account for about one-half of the available data on age. In order to prevent these data from confounding patterns in the rest of the country, we conducted analyses both including and excluding NYC figures. The exclusion made little difference in findings--no more than 2.5 percentage points in the category with the greatest difference and much less in other categories. For this reason, findings are presented for all responses combined.

Figure 2-6 shows the percentages of heads of household in elderly developments which fall into each of four age categories. Figure 2-7 shows the same data for elder heads of households living in family developments. The first category includes only ages 62 to 64, and is something of an artifact of HUD reporting requirements. Figure 2-6 shows that about 58 percent of elder heads of household in elderly developments are under 75; about 28 percent are between 75 and 84; and about 14 percent are 85 or older.

Figure 2-6: Age of Residents
(Elderly Developments - in percents)

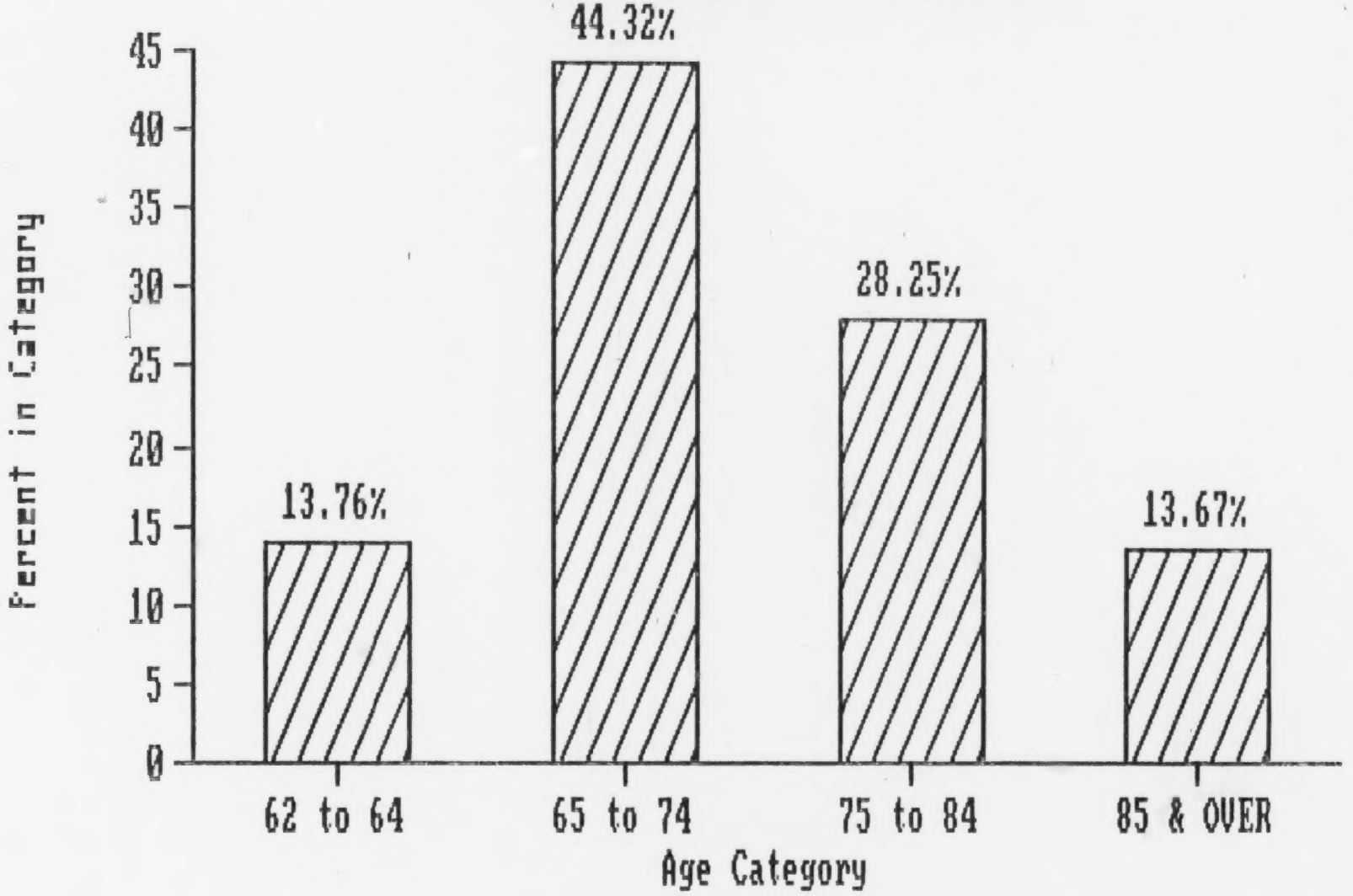
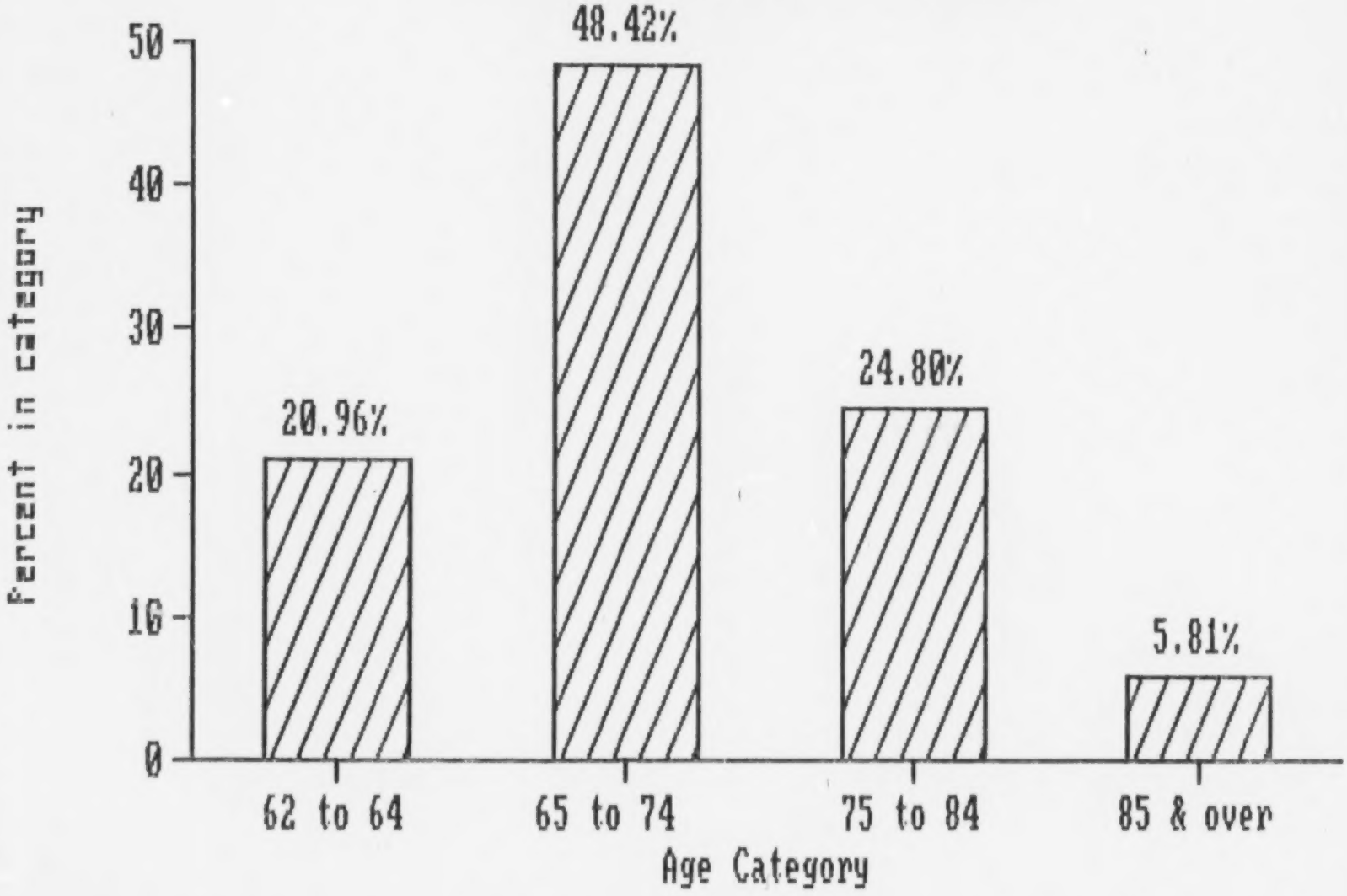


Figure 2-7: Age of Residents
(Family Developments - in percents)



Family developments have a somewhat higher proportion of "younger elders": about 69 percent are under 75, 25 percent are 75 to 84, and the remaining 6 percent are 85 or older.

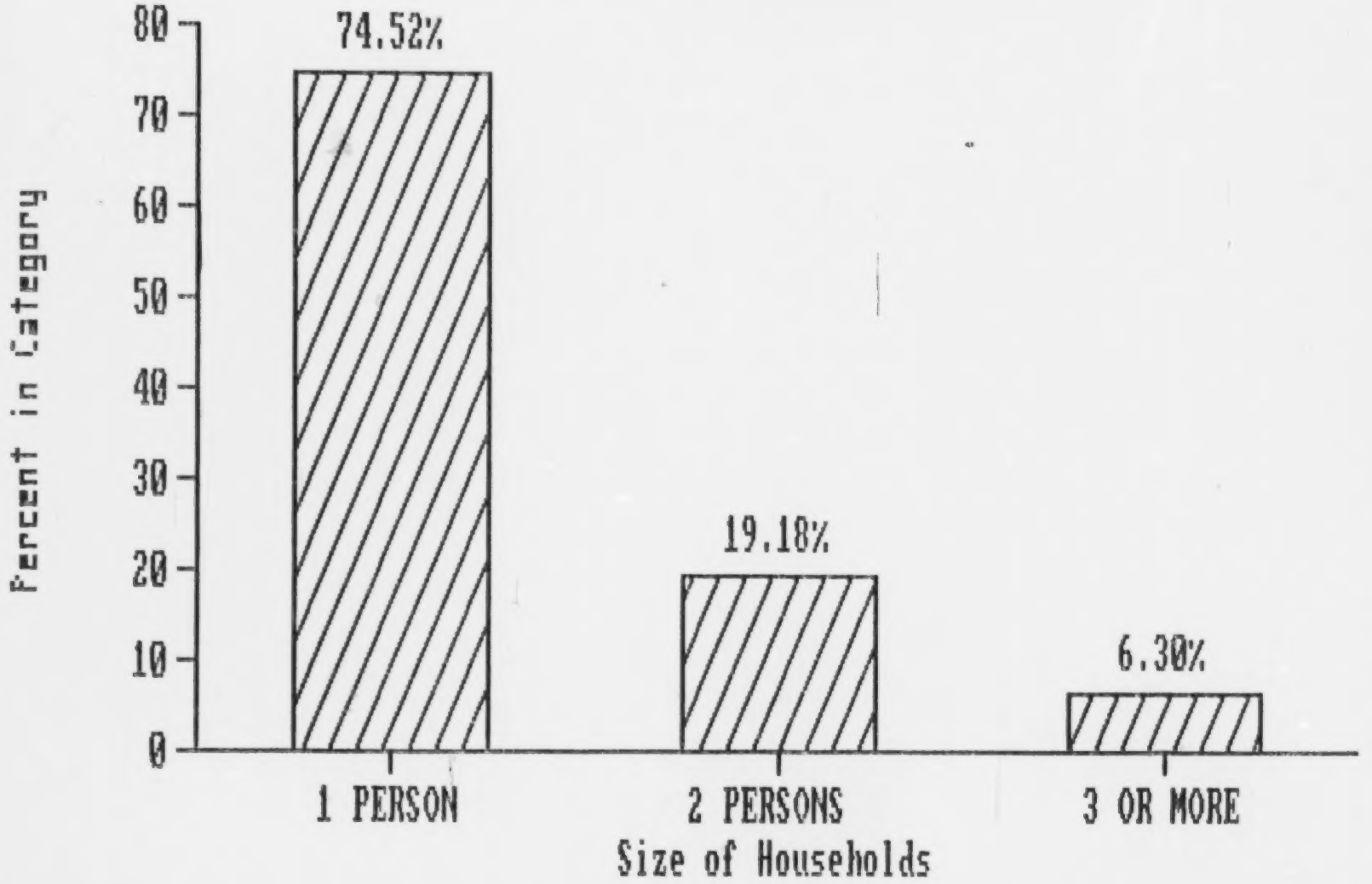
It is not clear what causes these differences between types of developments. In part, certainly, they illustrate the phenomenon of "aging in place" described in the introduction to this report. The original resident group in elderly developments usually moved in at about the same time and has been aging as a cohort since that time. The result is that the average age has increased, and managers are now faced with an older, frailer population than at any time in the past. Since family developments were usually rented up earlier and to a more diverse tenant population, this pattern is not found there. A further possible explanation is that independent living is more difficult in family developments. If this is the case--e.g., due to more barriers, fewer or less relevant services, or more social problems--elders might have to move out of such developments under circumstances in which they could remain in elderly developments. Other explanations might include transfers from family to elderly developments within the same PHA, or housing authority policies.

In addition to the 32 PHAs on which this analysis is based, another 32 were able to give us age data in various unstandardized categories. Because of the lack of comparability, these data were excluded from the formal analysis. Examination of responses, however, shows patterns which are similar to those reported here.

Household Size

Data on the size of elder households is shown in Figure 2-8.

Figure 2-8: Size of Elder Households
(in percents)



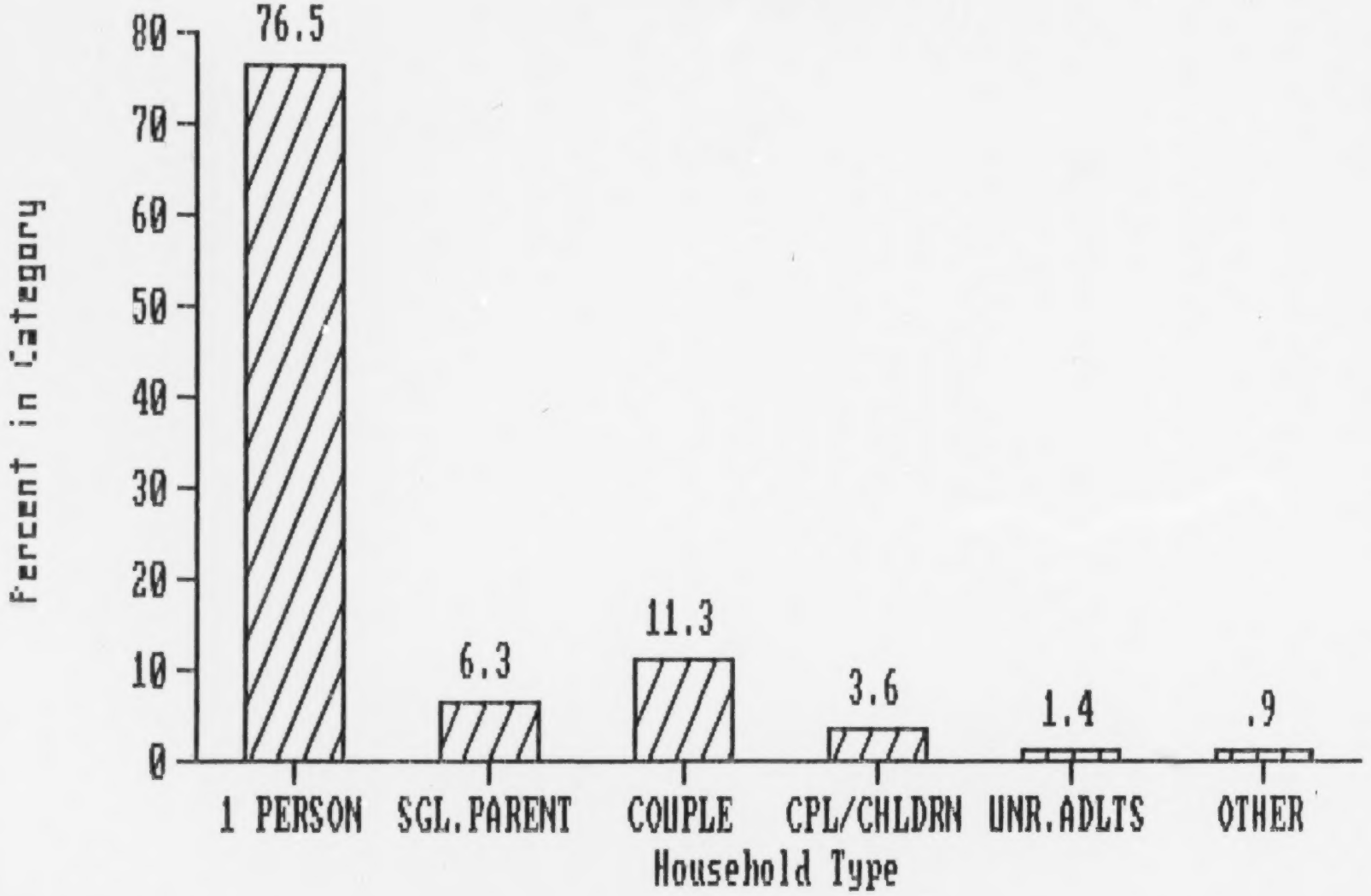
About three-quarters of these households are one-person; about 19 percent are two-person, and the remaining six percent comprise three or more people.

This finding shows that most elders in public housing do not have assistance within their immediate family. A person who lives with others can often call on them for help in a wide range of situations--shopping, carrying heavy loads, remembering to take medicine, housekeeping, and the like. A person who lives alone must find help elsewhere--from family members who come to visit, from friends or neighbors, or from service providers. In public housing, the manager and other PHA staff are usually the most accessible potential helpers, at least during the hours they are on-site. As we shall see in later chapters of this report, their ability to help varies with training, funding, knowledge of referral possibilities, and their job descriptions and available time, to mention only a few factors. As a result, some elders have actual help available to them and others do not.

Household Composition

Figure 2-9 adds more detail to the findings in the previous subsection. It shows the types of households that elders in public housing live in. Here again, about three-quarters of the residents live alone. (The figure is not identical to that for one-person households in Figure 2-8 because of different missing cases in the two data sets; however, the differences are insignificant.) About 11 percent continue to live with a child or children--presumably in family developments in most cases. About 15 percent of the households are couples, with or without children present. Only 1.4

Figure 2-9: Types of Elder Households
(in percents)



percent live with an unrelated adult--a situation that might sometimes indicate the presence of a caregiver of some sort.

Disabled Household Members

Of the 98 PHAs which responded to the survey, 78 were able to provide counts or estimates of the percentage of elderly households with a disabled member (33 counts and 45 estimates). These figures ranged from a low of zero--reported by three PHAs--to a high of 90 percent, reported by two. The median response was 15.

If 15 percent of the households served by the typical PHA have at least one disabled member, the need for special attention is clear. Modifications to buildings and units can help a disabled person live more independently. So can services. Since the large majority of households are one-person, it seems likely that most disabled elders live alone. Informal services from family and friends may be possible in some cases, but will not predictably be available. Here, too, the ability of the resident to continue to occupy his/her unit through crises or changes of health is likely to be highly dependent on service availability.

Household Income

The central-level questionnaire asked PHAs to report income data in three categories: $0-$2,999, $3000-9,999, and $10,000 and over. The middle category was so wide, however, that it captured over 85 percent of the responses. The development-level instrument was changed to break the large category into two narrower ones: $3,000-5,999 and $6,000-9,999. The results are similar to the central data, but more informative, and so will be used here. For purposes of comparability, HUD's definition of net household income

was specified to the PHAs. Since this is the figure on which eligibility and tenant contribution to rent are calculated, it is a figure that PHAs generally keep in their records. It is basically gross current income net of certain allowable expenses, such as excessive medical or work-related expenses.

Figure 2-10 shows the data. About 5 percent of all households have net incomes lower than $3,000 per year; another 5 percent have incomes over $10,000. Most households (69 percent) fall into the $3,000 to $5,999 range. Eligibility requirements, of course, are the primary determinant of these patterns. Household income must be low before a household qualifies for public housing.

These data illustrate the inability of these households to pay for expensive services. Actual eligibility for a specific service will depend on guidelines established by the program that offers the service, however. It can happen that a public housing tenant will qualify for some services but have an income "too high" to be eligible for another, or that some will only be available at fees the household cannot afford. Such discrepancies across programs in requirements--and often in which components of income are counted in determining eligibility income--greatly complicate service planning.

HUD's reporting requirements require that incomes be reported in two categories:(1) below 50 percent of the area's median income and (2) between 50 and 80 percent of the area median. Our questionnaire also asked PHAs to tell us what percentage of their elder households fell into each of these groupings. A total of 59 PHAs responded; three were dropped because their estimated added to more

Figure 2-10: Household Income
(In percents)

than 100 percent. Among the remaining 56, a median of 83.5 percent of the households were below 50 percent of the area median; a median of 15 percent were between 50 and 80 percent of the area median. This, too, indicates that a large majority of these elder households have very low incomes.

Income Sources

Data on income sources were somewhat difficult for PHAs to provide. Nevertheless, figures were provided by 54 PHAs on the central level and the sample PHAs on the development level. The findings are shown in Figure 2-11. Because there was some difference between central-level and development-level figures, both sets are shown. (Percents do not add to 100 because families can have more than one income source. The categories are therefore not mutually exclusive.)

The primary differences are in percentage of households with wage, Social Security, Supplemental Security Income (SSI), and pension income. The pension category is smaller on the central level because it was not explicitly included in that questionnaire. When it appeared frequently as an "other" category, we decided to include it in the development level question. The other differences are largely due to the impact of New York City on the central level data. In NYC, 15 percent of all elderly households have wage income, only 67 percent have Social Security, and only 9 percent have SSI. If NYC were excluded, the central level data would be more like the development level, where NYC does not have the same influence.

The patterns are similar in both data sets, however: most

Figure 2-11: Income Sources for Elder Households (in percents)

households receive Social Security. No other income source reaches as much as a quarter of the elder households. SSI is the second most common source, with private pensions apparently third. It appears from these data that most elder households in public housing rely heavily on Social Security and SSI. Even if 15 percent have pension income and 11 percent have wage income (the high estimates in each category), this still leaves three-quarters of these households without private income. Changes in federal policy with regard to Social Security and SSI--payment levels, cost-of-living adjustments, cross-accounting with other grant programs, and the like--will have a large and immediate impact on these elders.

Race and Ethnicity

In the country as a whole, white households are the largest elderly ethnic group served by these large urban PHAs. Blacks are a close second and Hispanics a distant third (See Figure 2-12).

These aggregate figures obscure some underlying patterns, however. One such pattern is that elderly developments appear to have a much higher proportion of white residents than is found among elders in family developments. This is illustrated by Figure 2-13, which shows ethnicity among eight PHA which reported only on their elderly developments. (Figure 2-12 shows combined data from elderly and family developments, which is how we asked PHAs to report the data.) In these PHAs, over 60 percent of all households are white, about 36 percent are black, and other ethnic groups are only negligably represented. These eight PHAs are by no means a representative sample, of course, but the patterns found here are similar to those found in other research.

Figure 2-12: Race/Ethnicity
All Elder Households (in percents)

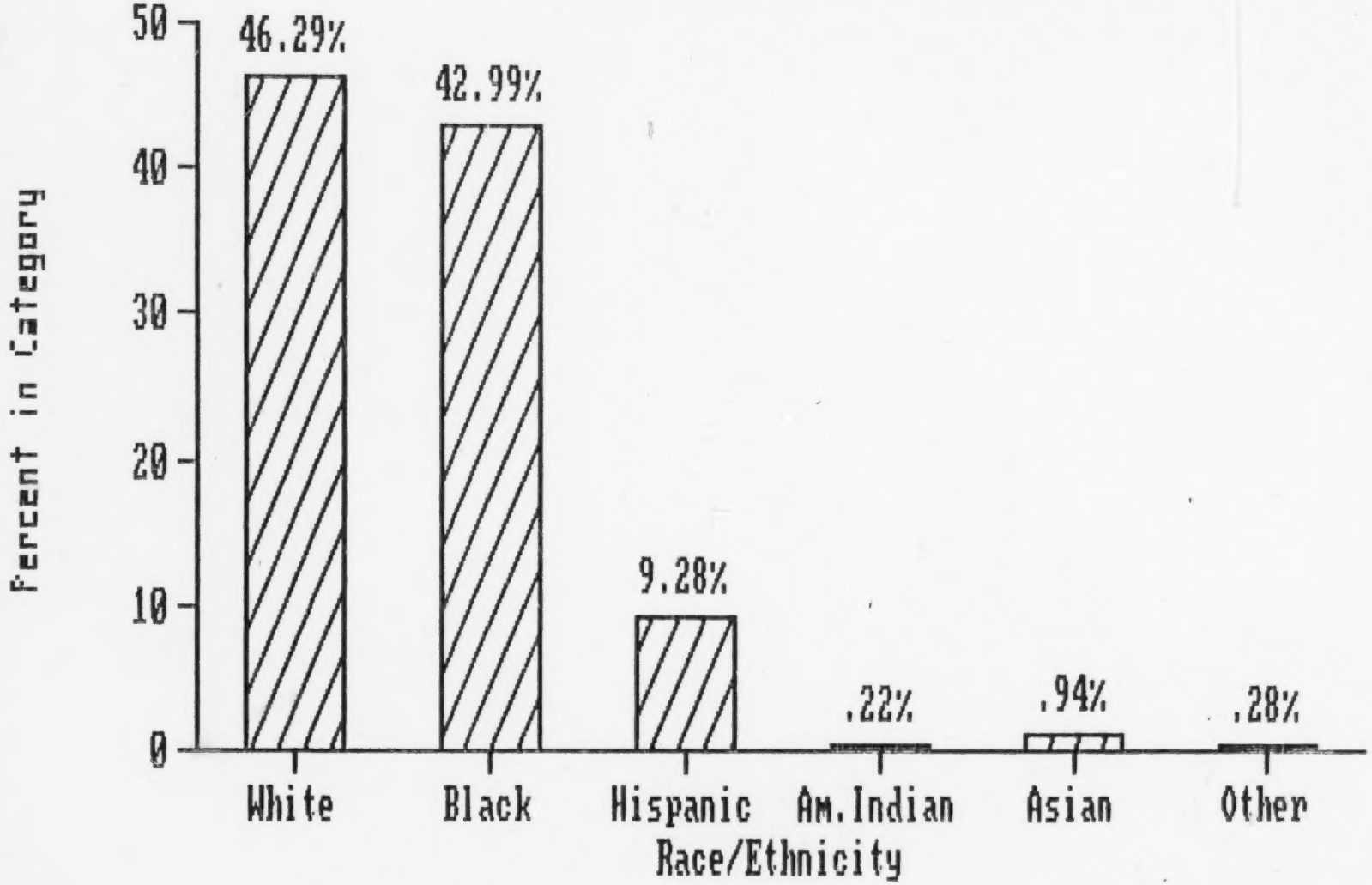
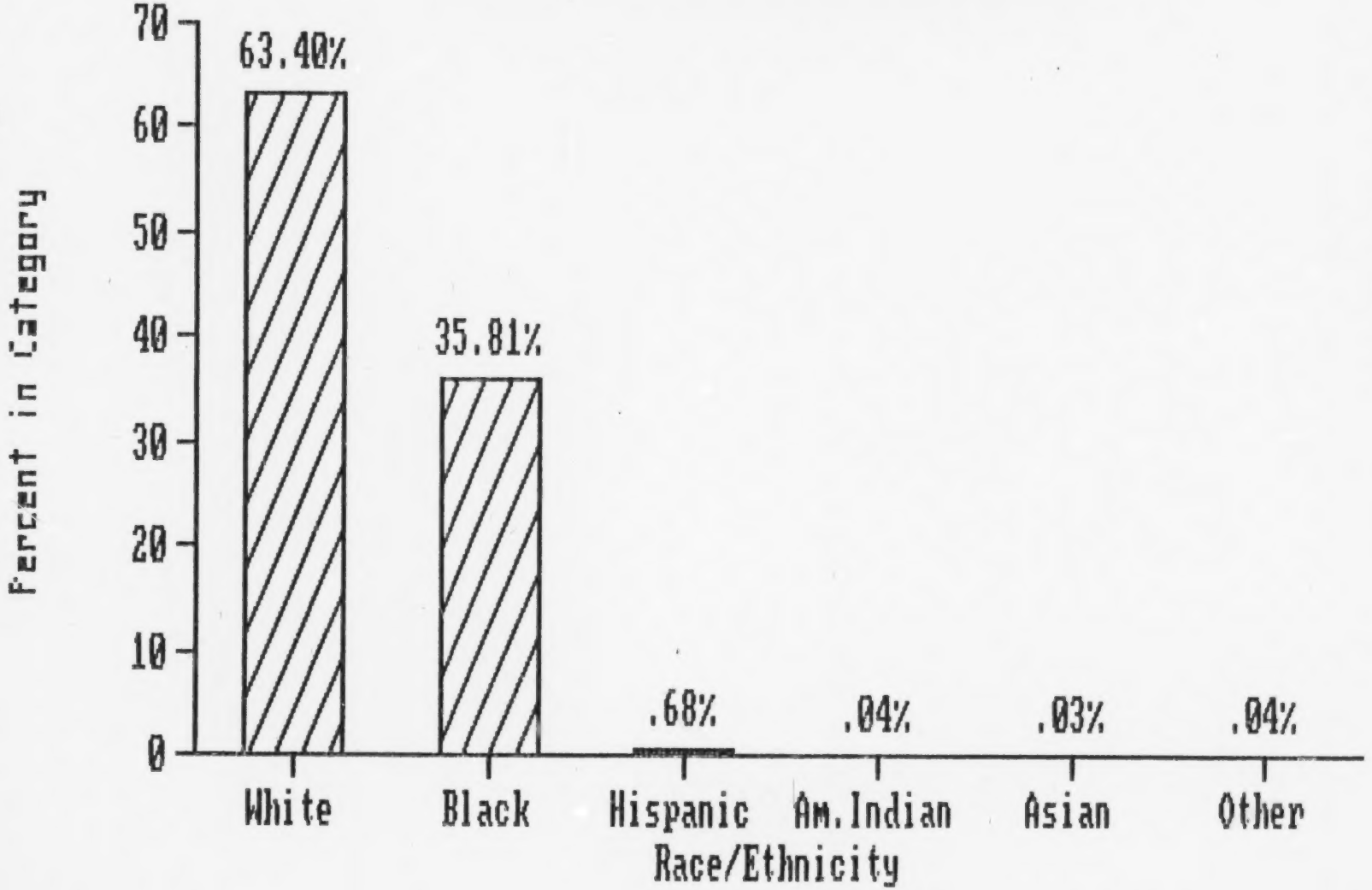


Figure 2-13:Elder Development Ethnicity
(From 8 PHAs with only elder numbers)



A second underlying pattern is that New York City tends to have more minority elders--black and Hispanic, particularly--than most other PHAs. In NYC, 27 percent of elder residents are white, 50 percent are black, and 22 percent are Hispanic. If NYC data were excluded, the minority percentages in the remaining PHAs would be ceably lower.

2.5 Elders Leaving Public Housing

Both surveys asked respondents to report or estimate percentages of elder units which became vacant during the past year for which they had records. The mean figure on the Central instrument was 13.3 percent; on the Development instrument it was 15.6.

Respondents were also asked why residents had moved out. Many PHAs did not have these data at the central level and were reluctant to make estimates. As a result, only 59 responses were received among the 100 PHAs which completed the Central instrument. Data availability was somewhat better at the Development level: 36 of the 39 managers were able to give us either a count or an estimate. Responses from both surveys are shown in Table 2-2 on the following page.

There are minor discrepancies between the two instruments, but they are generally similar. They show that about a quarter of the elder residents who moved out of these developments moved in with family or moved to other independent housing. Another quarter moved to nursing homes or some other type of care facility--for example a hospital or rehabilitation hospital. About 40 percent

Table 2-2

Elder Residents Leaving Public Housing

Reason for Leaving	Percentage of vacating residents who left for this reason...	
	Central Instrument	Development Instrument
Moved in with family	11.0%	8.2%
Moved to other independent housing	12.1	19.7
Moved to nursing home or other care facility	28.5	26.6
Died	40.3	38.3
Other	8.0	7.2
	N=59	N=36

Source: Central and Development-level instruments

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died. The remainder left for various reasons. (The one named most frequently by PHAs was eviction.)

The elders most likely to be impacted by services of the type discussed in this report are the quarter who moved to nursing homes or care facilities. Such moves are appropriate, of course, for elders who need permanent care of the type offered by nursing homes. They are inappropriate for those who are only temporarily in need of such care, or who could live independently with a level of care somewhere between independence and that provided by nursing homes.

Given these percentages, it appears that about 9000 elders move from public housing to nursing homes each year in these PHAs. There is no way to determine how many of these moves might be avoidable, but the number is large enough to justify efforts to

prevent unnecessary moves.

This concludes the discussion of developments, units, and the demographics of elder households. The following chapter will examine PHA policies and procedures which effect elders, and some of the problems PHAs report with regard to their elder residents.

.0 PHA POLICIES, PROCEDURES, AND MANAGEMENT PROBLEMS

The ability of elders to "age in place" in public housing is ery much influenced by the formal and informal policies and proce- ures adopted by PHAs. This chapter begins by examining a number f important policies--admission, retention, collection of informa- ion about current and prospective tenants, and discharge planning fter hospitalization--as they impact elders' residence. Our data lso give us some clues about PHA attitudes and the intent under- ying their formal policies. The chapter concludes with an analy- is of management problems reported by PHAs in connection with heir elder tenants.

This chapter relies primarily on survey data. It attempts to escribe the range of activities and policies reported to us by HAs. Chapter 5.0 will present a more detailed discussion of pecial efforts under way in some PHAs to deal with issues related o "aging in place".

.1 Admission Policies

In general, PHAs' selection criteria and priorities for elder pplicants are similar to those for families. Priority is usually iven to persons displaced by public action or eviction, and to hose with high rent burden or very low income. About half the HAs seem to have some residency preference, though it is not often iven as high priority as other criteria. Other priority cate- ories that were mentioned frequently include veterans and persons n substandard or dangerous housing.

The median number of persons on PHA elderly waiting lists was 78; across PHAs this number ranged from zero to almost 11,000.

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Not surprisingly, the larger PHAs tended to have the longer waiting lists. The time that a potential applicant was likely to remain on a waiting list also varied greatly. Median waiting times ranged from two months for a zero-bedroom unit to six months for a one-bedroom and eight months for a unit with two or more bedrooms. A few PHAs said that there was no waiting time at all, while some reported waits up to five years for a two-bedroom unit and six years for a larger unit.

Data were analyzed for relationships between length of waiting list, stringency of application policy, and number of elders served by a PHA. None of these variables was closely related to waiting time, however. While the PHAs with no wait list tended to say there was a very short waiting time, there was little relationship between number on the waiting list and expected waiting time among other PHAs. Nor were larger PHAs or those with the most stringent application policies (with regard to independence required of elder applicants) necessarily those with the longest waiting times for units.

It was clear from exploratory conversations with PHAs that there is variation in the criteria they apply for acceptance of an otherwise-eligible elder applicant. Some require an ability to live completely independently, while others are willing to accept some dependence either on services or on the PHA staff. Our questionnaire asked PHAs to check one of a series of statements about formal or informal policy:

(1) Applicants must be capable of complete independent functioning without any assistance;

(2) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units, and can arrange for this assistance;

(3) Applicants may be offered units if they need minimal services to assist in maintaining themselves and their units even if they must rely on PHA staff to arrange for these services;

(4) Applicants may be offered units even if they need ongoing assistance, as long as they can arrange for all supportive services; and

(5) Applicants may be offered units if they need ongoing assistance, even if they must rely on PHA staff to arrange for these supportive services.

(An "other" category was also available, but no PHAs chose to use it.)

A total of 92 PHAs responded to this question. Of those, 30 percent said that they required complete independent functioning. Among the remaining PHAs, the level of services required seemed to be less important than who would be responsible for arranging them. Thirty-five percent said that applicants who needed minimal services could be admitted if they could arrange for the services themselves. Another 20 percent said that those who needed ongoing services could be admitted if they could arrange for their own services. However only a few were willing to accept applicants who would have to rely on PHA staff to arrange services, whether the services were expected to be minimal (3.3 percent) or ongoing (6.5 percent). It is interesting that a slightly higher percentage chose the "ongoing" rather than the "minimal" category, among PHAs willing to have some applicants relying on their staff for services. The conclusion seems to be that only about ten percent of the PHAs are willing to accept such applicants; but if they <u>are</u> willing, then they will often accept those who need more-than-minimal assistance.

Managers who responded to our development-level questionnaire were asked the same question about the developments they manage. Their answers were in general accord with those of administrators on the central instrument cited above, though slightly more liberal about admission criteria. It is interesting to note that managers of elderly and congregate developments were much more likely than managers of family developments to say that elders with service needs could be admitted. Among elderly and congregate managers, 41 percent said that applicants with ongoing needs could be admitted, compared to only 11 percent of family managers. In congregate developments, two out of the four managers surveyed said that applicants who had to rely on PHA staff for ongoing services could be admitted. Although the number is small, this may indicate that congregate developments have more willingness or more ability to take on the problems of elders who are not able to live alone without regular services.

Applying Admissions Criteria

If a PHA wants to know how capable of independent living an applicant is, the PHA must have some process for assessing applicants' abilities and some screening process for deciding which applicants can be accepted. These matters are discussed in detail in Chapter 5 of this report, in connection with an examination of how particular programs are designed and operated. It is enough at this point to note that some PHAs have only rudimentary procedures in place, and that identifying an elder applicant who is incapable of independent living is largely a matter of chance. If a potential problem comes to the attention of an interviewer or a staff

member conducting a home visit, then some additional step will be taken--perhaps requiring the applicant to bring in a physician's statement that she is able to manage on her own. Other PHAs, however, have well-defined procedures for making this determination. Such procedures may spell out how applicants are screened, what "warning signs" should be noticed, how an applicant's family and/or advocates are to be involved in decisions that take place, how an assessment of daily living skills will be made, and by whom, and similar matters.

Some PHAs, for example, seek to have a family member or other "sponsor" assume formal responsibility for assisting the PHA in the event of a future problem. If the applicant is accepted and later needs intervention of some sort, the PHA has someone to call in at that point, rather than beginning to search for an appropriate person after a crisis arises. PHAs who have assessments done are able to use the assessment to help them assign new residents to the most appropriate development--usually the one with the best service mix for that person. Without some objective criterion such as an assessment, however, such assignment can seem arbitrary and possibly discriminatory to applicants and their advocates.

Our development level questionnaire asked managers of our sample developments to tell us about information gathered before an elderly tenant moves in. The types of information listed in the question were (1) level of independent functioning, (2) medical history, (3) social network, and (4) services currently received. Respondents were also asked to indicate whether the information was collected from all elderly, only from those who seem to present a

potential problem, or from none. The responses are shown in Table 3-1.

TABLE 3-1
PRE-MOVE INFORMATION COLLECTED BY SAMPLE PHAs

	Collected from all elderly	Collected from some only	Not Collected
Level of independent functioning (N=39)	43.6%	41%	15.4%
Medical history (N=39)	35.9	41	23.1
Social network (N=39)	48.7	30.8	20.5
Services currently received (N=38)	28.9	44.7	26.3

Source: Development Level Instrument

Most of the sample developments collect some sort of information from potential tenants. Almost half gather information from all in-coming elders on level of independent functioning and on family and friends who might be available to provide assistance to the resident. The sample is fairly evenly split between those who collect information on all prospective residents and those who only do so if there seems to be a potential problem. Only about one-quarter of these developments collect no information before a new resident moves in.

These data say nothing about how such information is gathered, or what use the manager or staff make of it. Chapter 5 of this report examines these matters, using case studies of some PHAs and developments to show the variety of practices taking place. We found, for example, that some PHAs conduct full-scale functional assessments, while others have them conducted by an elder service provider agency, and still others ask for letters from physicians.

Most PHAs seem well aware of the need for procedures which protect both the PHA and the applicant at this point. Forty-two percent of our respondents said they had adopted formal policies with regard to admission criteria. Others have relatively clear informal procedures, and still others are working to achieve greater clarity.

3.2 Retention of Current Residents

HUD regulations require that a resident's financial eligibility be redetermined annually. Some PHAs use this recertification as an occasion for assessing the appropriateness of an elder resident's continued tenancy. (Many find the process of recertification itself so time-consuming and intrusive that they try to avoid adding any potentially traumatic elements at this time.) A question of retention can also arise at any point, of course. If a tenant has an accident or is hospitalized, if staff or other tenants complain about a resident's behavior, or if the manager learns that a unit is not being maintained properly, the question must be asked. It becomes the PHA's responsibility--usually the site manager's--to learn the facts and to take appropriate action.

Our questionnaire asked PHAs to report their retention policies and practices to us in the same categories given above for admissions. (Our questions were reworded to ask about retention, but the range, from "complete independence" to "ongoing services which the PHA will have to help arrange", was identical.) The responses showed more widespread willingness to be involved with residents who need assistance than was found for applicants who need help. Only 10 percent of the 92 responding PHAs said that they required

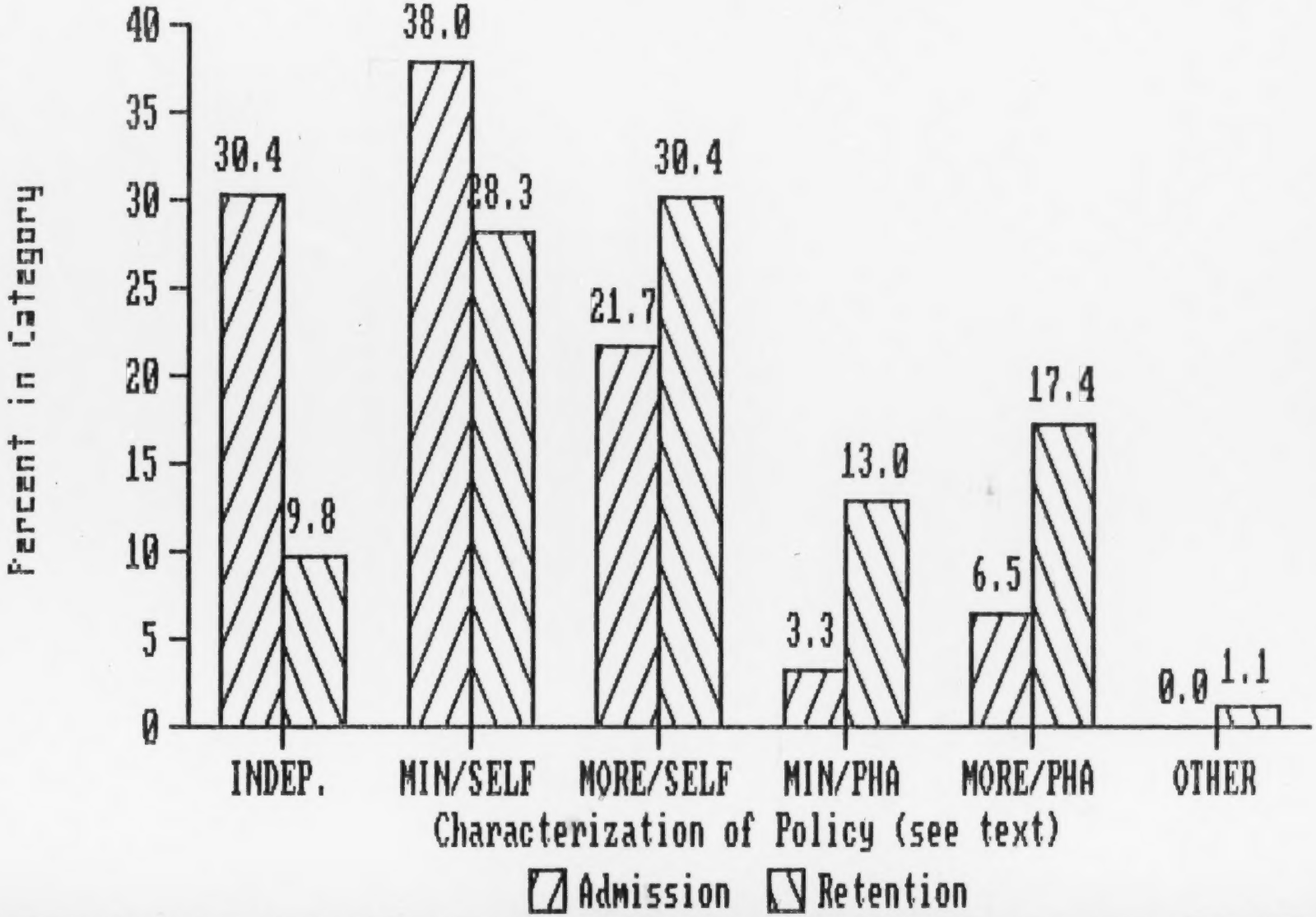
full independence for an elder tenant to remain in his/her unit; 28 percent will retain residents who need minimal assistance if they make their own arrangements; another 30 percent will do the same for residents who need ongoing services. PHAs are also more willing to offer staff time to these current tenants: 13 percent said they would retain elders who need minimal services plus PHA help to get them; another 17 percent said they would retain those who need ongoing services that the PHA would have to help arrange.

Thus, where only 9.8 percent of the PHAs said they would accept applicants who could not arrange for all their own services, 30 percent said said they would keep retain current tenants with the same level of need (see Figure 3-1). And while 30 percent required full independence from applicants, only 10 percent asked the same of current residents. Markedly fewer PHAs had formal policies on retention (27 percent) than had such policies with regard to admission (42 percent).

Finally, our central instrument asked administrators, "Do you have authority-wide procedures for making the determination that a tenant can no longer live independently?" Of 93 responding PHAs, 40 (43 percent) answered "Yes" and 53 (57 percent) answered "No". The responses by managers on the development-level questionnaire were almost identical in the aggregate. Responses by elderly and congregate development managers, however, were interestingly different from those of family managers. Half of the elderly and congregate managers, but only 20 percent of their counterparts in family developments, said they had such policies.

Descriptions of how such determinations were made varied con-

Figure 3-1: Admission and Retention Policies (in percents)



siderably. Some described routine home visits to be sure units were being properly maintained. Some indicated that the decision about retention was made by the manager alone, while others indicated that family members or other potential advocates would be called in. Several indicated that an assessment or medical evaluation would be done routinely if the feasibility of continued occupancy was in doubt. Some PHAs seemed primarily interested in protecting themselves and their units, while others seemed primarily interested in determining what would be best for the tenant. Any conclusions about PHA intent or motivation, however, are no more than conjecture, since these data do not address that issue. (See Chapter 5 for a more detailed discussion of how some PHAs handle such decisions.)

3.3 Monitoring Residents' Functional Status and Needs

Information on the needs of elder residents, both individually and in the aggregate, can be highly useful to a manager, service coordinator, or PHA administrator. Aggregate data can help identify needs, define possible service programs, and justify the resources such programs require. Individual information can help managers and others spot potential problems and bring in the appropriate resources.

However, gathering such information can easily be seen as an invasion of privacy--and may in fact be exactly that. Residents who see the manager primarily as a landlord may feel that they should conceal anything that might raise questions about their ability to live on their own. Elders, like people of any age, may be reluctant to admit some problems even to themselves. Residents

who feel the PHA is willing to offer them assistance when they need it will be more cooperative in such efforts than tenants who think the PHA is solely concerned with guarding its own property and staff time.

Here, too, we found a wide range of procedures. Many PHAs monitor the status of their elder tenants in regular ways, either in an ongoing way or through procedures linked to annual recertification. In other PHAs, some managers gather monitoring information while others do not.

Our questionnaire asked central administrators, "Does your housing authority collect information routinely about elder residents concerning the following, either authority-wide or in some developments?

- Changes in level of independent functioning (e.g., ability to prepare meals or maintain unit)
- Services requested or received
- Medical history (e.g., physical impairments, medications, and hospitalizations or other emergencies).

For each item, respondents could check "Yes, authority-wide", "Yes, some developments", or "Not collected. The results are shown in Table 3-2.

TABLE 3-2
INFORMATION GATHERED REGULARLY BY PHAs

	Collected Auth.-wide	Collected in Some Devs.	Not Collected
Level of independent functioning (N=88)	30.7%	20.5%	48.9%
Services requested or received (N=81)	25.9	18.5	55.6
Medical history (N=86)	25.6	22.1	52.3

Source: Central Instrument

About one-quarter of the responding PHAs collect each type of information listed in Table 3-2. In general, those who collect any one type also collect the other two, though a few collect only one or two. (Those who collect information authority-wide generally do so across all three types, too.) About half do not collect any of the three types listed.

It is interesting to compare the responses from central-level administrators with those we received from the site managers of our sample developments. Managers were asked a similar question which included one additional category of information: information on a resident's social network. Managers were asked to tell us whether information was collected from all elder residents, only from those for whom there might be a problem, or from none. Their responses are shown in Table 3-3.

TABLE 3-3
INFORMATION GATHERED ON CURRENT RESIDENTS (SAMPLE DEVELOPMENTS)

	Collected from all elders	Collected from some only	Not Collected
Level of independent functioning (N=38)	26.3%	28.9%	44.7%
Medical history (N=39)	28.2	33.3	38.5
Social network (N=39)	41.0	38.5	20.5
Services Currently received (N=37)	21.6	40.5	37.8

Source: Development Level Instrument

About half the central level administrators said that no information was collected, even at the development level. However, these managers give a somewhat different picture. They agree with

regard to information about level of independent functioning, but are more likely to say that medical and services information is collected. (The "social network" question was not included in the central instrument.) These differences could be due simply to sampling error, of course. But since our sample was randomly chosen, and since both differences are in the same direction, it seems likely that a real difference in perception is present. The managers seem to be gathering more information than the central-level administrators are aware of.

Within these rather broad categories, the ways managers collect this information, what they collect, and what they do with it vary considerably. Chapter 5 of this report discusses approaches used in various PHAs to monitor residents' status and to make service and placement decisions on the basis of the data they gather.

3.4 Hospitalization and Discharge Planning

Central-level administrators were asked whether their PHAs had a formal policy governing involvement in discharge planning when an elder resident has been hospitalized. They were also asked whether they had policies governing how long units would be held open for a resident who was in the hospital or another temporary care facility. Of the 94 PHAs that responded to the question, only 8 (8.5 percent) indicated that they had such a policy; 18 (19.1 percent) said they had a policy about holding units. However, several additional PHAs described informal policies in answer to both questions.

Responses by managers on the development-level instrument were similar. However, the discharge planning question was asked some-

what differently. Rather than asking about a formal policy, we asked "...is a representative of the housing authority routinely involved in discharge planning...?" About 20 percent of the managers answered "Yes" to this question. Responses from family managers were similar to those of elderly and congregate development managers.

In the relatively few developments in which staff were regularly involved in discharge planning, this responsibility was assumed by various people--the manager or assistant manager, tenant services specialists or aides, and the director of one congregate program. Some described processes initiated by PHA staff, while others said that the initiative was left to the hospitals. In some cases the manager initiated an assessment of the elders' ability to maintain themselves and their units upon return. PHAs are clearly concerned both about their units and about the best situation for the elder-person. One manager said, "We try to [be involved]. Hospitals now with DRGs are sending back folks so quick that adequate planning isn't occurring." These responses are too few to permit many generalizations. One implication may be that this type of involvement is more likely to happen if a manager has someone else who can take on the task--e.g., an assistant manager or services specialist.

In describing policies with regard to holding units while a tenant is in a temporary care facility, the common denominator in all responses was that the rent must be kept current. About a third of the PHAs that wrote in descriptions had policies that specified the time a unit would be held. Among these, about half said one or two months and the other half said three months (or 90

days); one PHA said six months. The remaining two-thirds of the PHAs described flexible processes with no fixed time period. Here, too, PHAs balance the resident's interest and that of the PHA itself. Responses ranged from "As long as it appears resident may return" to "Doctor's evaluation is required stating tenant's inability to live independently before Notice of Intent to Vacate is requested." One response said, "The manager is responsible for monthly follow up with family members, physicians, social workers, etc. so as to determine the tenant's ability to return."

3.5 Management Problems

Generally, policy and procedures develop as a response to actual or potential problems. Administrators and managers attempt to rectify situations that need improvement and to avoid difficulties they think may be developing. It is therefore instructive to look at managers' and administrators' perceptions of problems relating to elder residents. When similar problems exist across a range of PHAs, developments, and residents, it may be an indicator that some systemic element is present--something inherent in dealing with elders, perhaps, or something that many PHAs tend to do or to perceive. This, in turn, may help us find points at which new policies or resources are needed.

Respondents to both the central and the development-level questionnaire were given a list of management problems that might exist in some developments. They were asked to indicate which problems, if any, existed in their developments, and to rank which were the greatest problems and which were less severe. The central level question distinguished between elderly and family developments, and

applied to the PHA's developments generally. The development level questionnaire applied to the particular developments drawn in our sample. Table 3-4 shows the problems listed in the questionnaire, the percentage of responding PHAs which named each problem, and the percentage citing it as a major problem--i.e., ranked one, two or three on a scale of ten.

Table 3-4 lists problems in the order of frequency of mention in elder developments, beginning with those cited most often. Note that this order does not exactly correspond to the frequency with which problems were cited as major, or to their mention in family developments. PHAs which checked any problem for elderly developments were included as nonmissing cases for the elderly columns; similarly, any PHA which responded to any family item was included in that analysis. (In both cases, PHAs could also check off "none of the above"; those who did so were also included in the base for the analysis.)

Each item under elder developments was checked by at least half of the responding PHAs, indicating that all of the problems listed occur with some frequency. Three were cited by more than 80 percent of the PHAs: "elder residents' inability to maintain units", "obtaining family cooperation when needed", and "obtaining alternate placement for tenants no longre able to live in development". Two others were mentioned almost as frequently: "requests for services beyond the PHAs capacity to provide", and "alcoholism".

These responses show something of how PHAs can be caught between the residents' needs and those of the PHA itself. The first shows that in a very large proportion of the PHAs (88.4 percent),

TABLE 3-4

MANAGEMENT PROBLEMS CITED BY ADMINISTRATORS

	Elder Developments		Family Developments	
	Problem	Major Problem	Problem	Major Problem
Elder residents' inability to maintain units	88.4%	61.6%	70.3% *	42.2%
Obtaining cooperation of family when needed	87.2	55.8	76.7 *	42.2
Obtaining alternate placement for tenants no longer able to live in develop.	84.9	65.1	71.9 *	46.9
Requests for services beyond capacity of PHA	75.6	46.5	65.6	39.1
Alcoholism	70.9	46.5	64.1 *	29.7
Crime against elderly	64.0	18.6	78.1 *	50.0
Inability to provide or arrange needed services	62.8	24.4	60.9	14.1
Disputes among residents	60.5	30.2	82.8 *	54.7
Vacancies	58.1	30.2	54.7 *	17.2
Vandalism	57.0	9.3	68.8 *	43.8
PHA staff "burnout"	55.8	14.0	59.4	17.2
Disputes between elder residents & management	53.5	12.8	50.0	6.2
Other	10.5	N/A	9.4	N/A
	N=86		N=64	

Source: Central Instrument

NOTE: PHAs which did not check any response, including "none of the above" to the problem questions were excluded as missing cases. There were 12 missing cases for elder developments, 34 for family.

* The figure for family developments is statistically different at the .05 level or better from the corresponding figure for elderly developments, in a T-test of matched pairs--i.e., PHAs which responded for developments of both types. Responses for "major problems" were not tested for differences.

problems have been experienced with elder tenants who have become unable to care for their housing units. This is obviously a painful situation even if it happens only rarely. However, over 60 percent of the respondents indicated that this is a major problem for their PHA--an indication that it is not so rare.

The next two most frequently mentioned situations speak to the responsibility that a PHA can suddenly acquire when it faces a problem situation with an elder resident. If the resident has no family, or has lost touch with his/her family, or if the family will not take responsibility when a crisis arises, PHA managers and administrators may find themselves forced by default to make difficult decisions. A resident may be ill or unconscious, or may be mentally ill and unable to recognize it for herself. Often, too, --unless the PHA monitors such things--the manager may not know whether the resident has a relationship with a potential advocate such as a service provider. Situations of this sort can lead to another which was mentioned frequently--that in which a PHA determines that a resident cannot continue to live in the development, but finds itself to be the only party who can take responsibility for finding an alternate living place.

The item relating to service requests can have two meanings--both probably true to some extent. It may mean that elders make legitimate service requests that the PHA does not have the resources to fulfill through their own efforts or through referral. In this case, the problem is that more services are needed. A second interpretation is that elders make inappropriate service requests as a way of getting time and attention from the manager or from clerical or maintenance staff. In this case, the problem may be

that the elders need activities or visitors rather than more specific services.

The frequency with which alcoholism is cited is striking. It is a problem in almost three-quarters of the PHAs and a major problem in nearly half. This, too, underlines the isolation and despair that can come to be the elder's worst enemy. Living alone in a large public housing development with few services, residents may drift into dependence on alcohol or other drugs. Frequently, they then become problems to the neighbors and the management as well.

There are interesting differences between the responses relating to elderly developments and those relating to family developments in Table 3-4. (Recall that the question asked about elder residents in family developments, not about developments as a whole. Thus, responses such as "alcoholism" or "obtaining family cooperation" relate to elders, not to all residents. Some problems are development-wide, of course. Thus, citing "vandalism" as a problem does not imply that elders residents commit acts of vandalism.) Figures for "crime against elderly" and "disputes among tenants" are markedly higher in family than in elderly developments. Figures for "vandalism" are somewhat higher. These figures show that the social climate may often be less hospitable for elders in family developments than for their peers in elderly developments.

On the other hand, the incidence of several problems is greater in elderly developments. In particular, administrators cite the following:

- o elder residents' inability to maintain units
- o obtaining cooperation of family when needed
- o obtaining alternate placement for tenants no longer able to live in development
- o alcoholism
- o vacancies.

Some of these problems may be greater because of the higher average age of elder residents in elderly developments (see Section 2.4 above). The first three seem more likely to occur with an older, frailer population, since continued residency may be in question more often. Alcoholism may not be more frequent, but simply more visible, in elderly developments, where facilities are often designed to let staff observe the tenants, more so than in famiuly housing, and where group meals or other functions may be more common. The problem of vacant units exists in some PHAs which have found it difficult to maintain an active elderly waiting list. This problem is much rarer in family housing, except for some particularly distressed developments.

Perceptions of Site Managers and Service Providers

The managers and service providers who completed our development level questionnaire were given a list of potential problems similar to those in the central instrument. (Note that some items are changed to reflect an on-site perspective. Some, such as alcoholism, were listed as service needs rather than management problems in the development level instrument.) In contrast to central administrators, their responses should represent more of a "hands on" view--one based on particular developments and on experiences with particular elder residents and clients.

The data are reported in Table 3-5. It is interesting to note that the problem most often listed both by managers and by service

TABLE 3-5

MANAGEMENT PROBLEMS NAMED BY SITE MANAGERS AND SERVICE PROVIDERS
(Family, Elderly, and Congregate Developments Combined - in percents)

	Managers		Service Providers	
	Problem	Major Problem	Problem	Major Problem
Need for more services to support elder residents' health & safety	93.9%	69.7%	66.7%	54.2%
Elder residents' inability to maintain units	90.9	60.6	66.7	54.2
Elder residents' inappropriate requests for assistance (e.g., from maintenance staff)	87.9	39.4	37.5	20.8
Vandalism	81.8	30.3	50.0	12.5
Disputes among residents	75.8	39.4	62.5	29.2
Deterioration of physical plant	75.8	33.3	50.0	33.3
Crime against elderly	75.8	30.3	66.7	33.3
PHA staff "burnout"	69.7	33.3	50.0	25.0
Rent arrearages by elderly	69.7	12.1	33.3	4.2
Disputes between elder residents & management	66.7	9.1	37.5	12.5
Other	9.1	N/A	16.3	N/A
	N=33		N=24	

Source: Development Level Instrument

NOTE: Respondents who did not answer any part of the question were excluded as missing cases--6 managers, no service providers.

providers was "need for more services to support elder residents' health and safety." All respondents--administrators, managers, and service providers--seem to agree that the inability of some tenants to maintain their units is a major problem. In general, managers were more likely than central administrators to identify any given item as a problem. This probably means only that problems are more visible from the manager's perspective. Service providers cited problems in lower proportions than other respondents. This probably means only that they do not know whether some things are problems to the manager or not.

The problems that have been cited in this section serve as background to our discussion of services in the following two chapters. Given the occurrence of these problems (and others the questionnaire did not mention, no doubt), how well do PHAs and their elder residents cope with them? Are service programs available, either through the PHA or through other providers, to assist elders? Or do the problems remain largely unaddressed? Chapter 4.0 will look at survey data about service provision and use and about unmet needs. Chapter 5.0 will then show examples of how particular PHAs address such problems--examples that may point the way for policymakers at local, state, and national levels.

4.0 Services: Needs, Provision, and Gaps

The central questionnaire asked a few questions related to services and how they are provided, and about staff responsibilities and training. Most data on services, however, comes from the development questionnaire. In this instrument, managers and service providers were asked a series of questions about the problems faced by elder residents, what services are provided, how extensively they are used, major unmet needs, and, finally, about factors which are barriers to service delivery.

This chapter addresses all of these issues. It begins with a discussion of PHA staff capabilities, general responsibility for service provision, and service and security facilities available at the sample developments. The second part of the chapter examines data on need, services, and utilization.

4.1 PHA Staff Responsibility and Training

Some PHAs employ service specialists at the central level, the site level, or both. Others have no one whose primary purpose is to provide or arrange for services. Even where services staff exist, much of the first-order responsibility falls on managers and on the clerical or custodial workers who are most visible to tenants. This is even more likely to be the case when no service specialists are present. Some PHAs expect management and even clerical and custodial workers to play a service role; they are told that this is part of administrators' expectations, and they may be given some training for these tasks. In other PHAs, the management role resembles that of a traditional landlord. Here, service needs or requests are likely to be seen as interruptions

that keep managers and workers from performing their "real" duties.

Both the central and the development-level surveys asked respondents to indicate whether service provision was part of the job descriptions of managers, central services staff, on-site services staff, and on-site clerical and custodial workers. Respondents were also asked about services actually provided by each of these groups, regardless of formal job description.

Table 4-1 shows responses from both instruments. The top part of the table shows that most PHAs (81.1 percent) regard some amount of service responsibility as part of the site manager's role. The managers of sample developments on the Development-level questionnaire, tended to agree: 72.2 percent said that "assisting elders to obtain services" was part of the manager's job.

The responses to the questions about services staff probably have a different interpretation from the responses about managers. Virtually all developments have a manager, even though he/she may not have an on-site office and may work primarily elsewhere. Not all PHAs or developments have tenant services staff. When PHAs and managers responded positively to this part of the question, it probably means that such staff exist in that place. Thus, in 60 percent of the PHAs, there are central staff with service responsibilities for tenants including elders. In 42 percent of the PHAs, there are services staff who work at the development level. The sample development managers' responses, again, tend to agree with those of central administrators: A slightly lower percentage cite central service staff; responses for development level staff are about the same.

The bottom half of Table 4-1 shows responses to questions about

Table 4-1

Responsibility for Services to Elder Residents

	Percent answering that services are responsibility of these employees: Central Instrument	Development Instrument
Manager	81.1%	72.2%
Central Tenant Services Staff	60.0	47.2
On-site Tenant Services Staff	42.1	44.4
Clerical or Custodial	27.4	22.1
	N=95	N=36 (Managers' responses only)

	Percent answering that services are actually performed by these employees: Central Level			Development Level	
	Routinely	Only in Emerg.	Differs Among Devs.	Routinely	Only in Emerg.
Manager	49.5%	26.3%	12.6%	44.4%	47.2%
Central Tenant Services Staff	45.2	15.8	3.2	36.1	44.4
On-site Tenant Services Staff	29.5	6.3	8.4	38.9	27.8
Clerical or Custodial	23.1	13.7	3.2	16.7	55.6
	------- N=95 -------			----- N=36 -----	

Source: Central and Development-level Instruments

which staff members actually provide elder residents with assistance in obtaining services. Comparing these figures with those in the top part of the table, two things become clear. First, in every employee category, a lower percentage routinely gives assistance than were said to be responsible for giving assistance. This implies that PHA expectations and job descriptions differ--some employees are expected to give assistance to elders as a part of their day-to day-work; others are expected to respond in emergencies, but not necessarily in everyday circumstances. This seems particularly true of managers.

Secondly, it is also clear that, counting emergencies, more employees of all types actually give assistance to elders than are formally expected to do so by PHA administrators. This seems especially true of clerical and custodial employees.

Responses by service providers to the development level survey were not included in Table 4-1. Their inclusion would complicate the table but would add little information, since they are in general agreement with managers' responses. One figure, however, is noteworthy. Where about 39 percent of managers said that assistance in obtaining services was actually given by on-site services staff, 87 percent of service providers gave this response. This seems to indicate that the service providers assume these sample developments actually <u>have</u> on-site service staff available to residents. In fact, based on managers and administrators' responses, fewer than half the developments actually have staff of this kind. If providers have unrealistic assumptions about the amount of "in-house" help available, they may be less likely to search for ways of working with the PHAs or their residents. In fact, there is no

ongoing, dependable funding for PHAs to deliver or arrange for services--though some, as we shall see in Chapter 5, manage to fund some services out of their operating budgets. Therefore the PHAs must usually find a way to work with provider organizations if services are to be available.

PHA Staff Training

Given the responsibility that PHA staff have for dealing with elder residents--including, as we have seen, giving services and assistance in many instances--it is reasonable to ask how capable they are at these tasks. Any real measure of such capabilities would go far beyond the scope of this study. However, our survey included questions on training received by staff of various types. Table 4-2 shows responses both by central administrators and by managers and service providers.

Table 4-2

Training Received by PHA Staff (in percents)

	Central Level	Development Level	
		Managers	Service Providers
	(N=92)	(N=38)	(N=21)
Managers	57.6%	68.4%	81.0%
Central tenant services staff	33.7	42.1	71.4
On-site tenant services staff	50.0	63.2	76.2
Clerical and Custodial staff	*	33.3	45.5

Source: Central and Development-level instruments

* These data are not available because of coding problems. However, they should be similar to development-level responses.

The data in Table 4-2 show that, according to central administrators, about one-third to one-half of the managerial and services staff who work with elder residents have received training from the PHA or arranged by the PHA. Managers' estimates in the sample developments are consistently a little higher, but generally "in the same ball park". Service providers' estimates are higher still. This again raises the question mentioned above. Do service providers tend to overestimate PHA staff capability for dealing with the needs of elder residents? If so, do they underestimate the amount of unmet need that actually exists?

Comparison of figures in Tables 4-1 and 4-2 leads to the impression that most staff who routinely provide assistance to elders have had some training to do so. This assumes that the more-or-less 50 percent of managers who actually give assistance are included in the approximately 60 percent of managers with training, and so forth. This cannot be demonstrated from the figures in the tables, but seems likely. It should also be noted that several PHAs which have not trained some types of staff say they attempt to hire staff who already have gerontological training and experience.

Perhaps the most basic finding in Table 4-2, however, is that <u>one-third to one-half of the responding PHAs have not given their staff training in dealing with elders and their needs</u>. Perhaps this gap is filled to some extent by those that hire staff who need no further training. In any event, it appears that many elder developments are managed and staffed by people without specialized training of this type. This might make little difference if these developments are well-provided with service and referral by outside providers. If they are not, however, the absence of trained staff

is more problematic. We now turn to an examination of the availability and use of services.

4.2 Facilities and Responsibility for Service Provision

Facilities and Security Features

Section 2.3 reported that about 80 percent of elderly developments have space available for recreational or educational use, and that about 72 percent have space available for service use. (This does not necessarily mean that the space is used for this purpose, or even that it is in useable condition.) This question was not asked about family developments. The Development-level questionnaire asked managers and service providers a somewhat more extensive question about service and security facilities. The components of the question and a summary of responses are shown in Table 4-3.

The first two columns in Table 4-3 show managers' responses; the two rightmost columns are responses by service providers. Note that the percentages enclosed in parentheses are based on a small number of responses, and therefore should not be taken as a very accurate estimate of circumstances in family developments. (They are estimates, however, and may be the best information available on the topic.) In general, the service providers' responses are similar to those by the managers, except that they seem more likely than managers to think that a development has some sort of system for checking on residents every day. (Presumably, the managers are more likely than an outside service provider to know whether or not this is the case.)

All elderly and congregate developments in the sample have some

Table 4-3

Service and Security Facilities (in percents)

	Managers		Service Providers	
	Eld.& Congr. (N=29)	Family (N=10)	Eld.& Cong. (N=19)	Family (N=5)
Lobby or other public "sitting room" space	100.0%	(60.0%)*	100.0%	(80.0%)*
Community space for meetings or service provision	100.0	(100.0)	100.0	(100.0)
Nursing station or other med. facility	37.9	(10.0)	42.1	(20.0)
Working intercom/ door buzzer system	69.0	0	63.2	0
Working emerg. buzzer or call system	79.3	(20.0)	89.5	(40.0)
Door cards or other system for daily check that residents are OK	37.9	0	68.4	(40.0)
Paid, on-site overnight staff for residents to call on in emergencies	51.7	(20.0)	57.9	(20.0)

Source: Development-level Instrument

* Table entries enclosed in parentheses are percentages based on a total N of 15 or less. They are less likely to be reliable measures than those with a larger base.

public "sitting room" space and some community space for meetings or service delivery. A Boston study found quite a bit of diversity in the extent to which sitting space is actually used. It reported that elders are most likely to use space that is near the entrance or lobby, where they can watch things happening on the street, watch for the mail to arrive, see people entering and leaving the building, and so forth. Space on the roof or top floor of a building, for example, is less likely to be used, even though it may be quieter and architecturally more attractive (Stockard and Stockard, 1985). Our survey did not ask about the location of space, however--merely about its existence.

Most elderly and congregate developments have working intercom/door buzzer systems and working emergency buzzers. The first is an important safety and convenience system. The other is important both for emergency use and for the peace of mind of elders who live alone.

About half the elderly and congregate developments have paid overnight staff who are on the premises overnight in case of emergency. This means, obviously, that half do not have such staff. (Our survey did not ask what kind of staff were available, nor how they were paid; chapter 5 has some program descriptions that provide these answers for particular programs.) Without staff of this kind, elders who become ill or injured outside office hours must call police, a rescue squad, an ambulance, or some other professional crisis service. This may often occur for a problem which could be handled by a PHA staff person, if one were available.

About one-third of the elderly and congregate developments have some system for checking on residents each day. One such system

uses cards that can be hung on the outside of residents' doors. If the tenant has not put his/her card out by a designated time each morning, someone--staff or another resident--is responsible for checking to be sure nothing is wrong. Other PHAs use a "buddy system", resident volunteers, or a telephone chain to accomplish the same purpose.

About one-third of the elder and congregate developments also have nursing stations or other health-related facilities of some sort. These may range from a nursing station staffed around-the-clock to monthly clinics which offer blood-pressure screening. One manager noted that "One floor is wholly occupied by the local health department, serving building elderly and operating an evaluation unit." Several others mentioned clinics staffed by visiting or public health nurses, medical students, or nursing students. Chapter 5 presents descriptions of some programs that were reported to us.

The picture in family developments seems to be quite different from that in elderly and congregate developments. Only 60 percent have "sitting space" and very low percentages have any of the other facilities or security measures listed. This finding shows again the major difference that can--and apparently usually does--exist between specially built elderly housing and family public housing. Elderly and handicapped developments are built to be barrier-free and normally contain safety features such as intercoms and emergency call buttons. Family housing does not usually contain these amenities. As we reported in Chapter 2, most PHAs do not routinely modify family units or buildings occupied by elder tenants. Fur-

ther, elderly and congregate developments seem more likely to attract service programs designed to meet the needs of elder residents. This question will be examined in more detail in the remaining sections of this chapter.

Basic Responsibility for Service Delivery

Most data on service needs and delivery was sought at the development level. However, the Central instrument contained a question which asked administrators to characterize the PHA's basic policy on service delivery. Elderly developments and family developments were separated so that different answers could be given for each of these two types. Respondents were given five choices of "policy characterizations", and were told to check as many responses as were applicable. The wording of the question and the percentage of responding PHAs which checked each category are shown in Table 4-4.

Because PHAs could check more than one response, the percents in Table 4-4 add to more than 100. The most striking difference between elderly and family developments in the table is in percent of PHAs which either provide services directly or by contract with a community service provider. About half the PHAs gave this answer for elderly developments, but only 30 percent for elder residents in family developments. In other categories, the responses for family and elderly developments are the same, for all practical purposes.

Some PHAs indicated that they assist in service delivery in informal ways, rather than through direct delivery or contracts with providers. The most common example was making space for

Table 4-4
Characterizations of Basic Service Approach (in percents)

Question: Which statements best describe your policies or practices on provision of services to elders, e.g. homemaker services, Visiting Nurses, Meals-on-Wheels? (PLEASE DISTINGUISH BETWEEN ELDERLY AND FAMILY DEVELOPMENTS. CHECK ALL WHICH APPLY.)

	Percent of PHAs checking response	
	Elderly Developments	Family Developments
Services such as these are provided in most developments directly by PHA staff or through PHA contracts with service providers in the community.	48.9%	29.9%
Services such as these are not provided in most developments, but the PHA has service staff who are available to all elder residents to help obtain services from community agencies.	43.5	44.8
Services and/or assistance to obtain them are routinely provided in some developments and not in others (e.g., depends on mananger's initiative, availability of special funding, etc.)	17.4	19.5
Services and/or assistance in obtaining them are provided only in emergency situations in all or most developments.	14.1	18.4
Services and/or assistance in obtaining them are not provided in most developments.	5.4	9.2
Other	5.4	3.4
	N=92	N=87

Source: Central Instrument

service delivery available free of cost to providers. (Recent changes in HUD regulations now make this difficult for authorities to do, however.)

This table does not indicate what services are provided or how widely or often they are available--that will be explored in subsequent sections. It does indicate, however, that a majority of PHAs routinely offer some services or referral in most elderly developments, with family developments served at a somewhat lower level. About 20 percent of the PHAs say that services are not usually available, or are available only in emergencies in elderly developments. (The comparable figure for family developments is about 28 percent.) Some 17 (elderly) to 19 (family) percent indicate that circumstances vary among developments. That is, the manager's initiative or the availability of special funding determines service availability, rather than a central PHA policy which applies across the board. The data also indicate that direct service involvement by the PHA--through provision or subcontracting--is relatively frequent.

4.3 Incidence of Problems among Elder Residents

Managers and service providers responding to the Development level survey were asked what percentage of the elder residents in each sample development experienced a variety of problems. Since managers and service providers gave separate responses, we are able to compare the extent to which they tend to agree about elders' problems. When respondents had need assessment data available to them, they were asked to use them in answering the question. If no objective data were available, respondents were asked to give their

best estimate.

The types of problems listed and the responses are shown in Table 4-5. The table shows both the mean percent across respondents and the range of responses given. The most common problems are social isolation, mobility impairment, depression, and memory impairment. By some estimates in Table 4-5, up to a quarter of all elder residents experience each of these problems. About ten percent experience alcoholism, and (if the service providers' estimates are accepted) self-neglect and "other emotional or cognitive impairment."

Estimates by service providers and managers are similar. Where there is s statistically significant difference--those marked with an asterisk on the table--the service providers' estimates tend to be higher than the managers'. In general, managers and service providers tend to agree on those problems which are most easily observed--e.g., mobility impairment, social isolation, erratic behavior. They differ most on problems which might be visible only to someone providing the resident with assistance, such as self-neglect, malnutrition, depression, and memory impairment.

When managers' responses are compared to those by service providers from the same project, they tend to be similar. However, some major disagreements are also apparent. One manager reported that 5 percent of residents suffered from depression; the service provider interviewed for the same development said that 75 percent experience this problem. Another manager reported that alcoholism is a problem for 30 percent of residents; the corresponding service provider response was one percent. These major disagreements were more common for the more subjective problems. There were only four

Table 4-5

Percentages of Elder Residents with Certain Problems

Problem	Managers Mean Percent	Managers Range	Service Providers Mean Percent	Service Providers Range
Social isolation	19.8%	0-58%	24.1%	0-60%
Mobility Impairment	19.8	1-75	22.3	2-85
Self-neglect	4.4	0-20	9.0*	0-60
Malnutrition	2.1	0-15	6.4*	0-40
Depression	13.3	0-71	27.3*	0-80
Alcoholism	9.9	0-50	9.0	0-30
Erratic behavior	5.4	0-35	6.6	0-20
Memory impairment	12.0	0-65	19.2*	1-77
Other emotional or congitive impairment	4.0	0-27	11.8*	0-40
Other	0.0	-	0.2	0-5
	N=32		N=21	

Source: Development level instrument

* The service providers' estimate is significantly different from the managers' estimate at the .05 level or better.

developments in which one respondent gave estimates that were consistently very much higher than those of the matching respondent. (In two cases the manager's estimate was higher, in two the situation was reversed.)

Sources of Information about Incidence of Problems

Only 8.1 percent of the managers reported having needs assessment data available to help them estimate the problems experienced by their rersidents; 64.8 percent said their response was based on personal observation or contact with other PHA or service provider staff members. Almost half--48.6 percent--said that no information was readily available.

Among service providers, 20.8 said they had need assessment data, and 83.3 said they based their responses on observation or staff contact. (The categories are not mutually exclusive: some used both information sources.) A quarter of the service providers said there was no information available. These numbers do not lead to the conclusion that service providers tend to have more information at their disposal than managers, though this sometimes seems to be the case. For many developments we were unable to locate any service providers who felt well enough informed to respond to our survey at all.

4.4 Percentages of Elder Residents Needing Help with Activities of Daily Life

Respondents to the Development level survey were asked to estimate the percentage of elder residents living in the sample developments who need assistance with various activities of daily living. The listed activities and the responses by managers and

service providers are shown in Table 4-6. Respondents were asked to consider only need in answering this question--not to take into account whether services were or were not provided or available.

In general, service providers' estimates tend to be slightly higher than those of managers. In four instances, the difference is statistically significant: preparing meals, monitoring health and medications, budgeting and paying bills, and social and recreational activities. Even these responses are relatively similar, however. No major discrepancy between managers' perceptions and those of service providers is evident in the table.

The most common need, according to both types of respondents, is for transportation. Transportation may be a problem for various reasons. Many elderly developments are located in suburban or even rural sites without convenient public transportation. Since many residents typically do not own cars or are unable to operate them, supplemental transportation of some sort is necessary under these circumstances. Elders with mobility impairments may be unable to use public transportation. Trips which require carrying heavy parcels may also be a problem.

The second most commonly cited need is for assistance with shopping, which can be a problem for all the reasons mentioned above. Caring for the unit ranks third. It will be remembered that the inability of some tenants to care for units was cited by PHA administrators as a major management problem (see Table 3-4). According to the estimates in Table 4-6, between a fourth and a fifth of all elder residents need help to manage this responsibility.

Smaller--but still significant--percentages need assistance

Table 4-6

Percent of Elders Needing Assistance with Daily Activities

Problem	Managers (Mean Percent)	Service Providers (Mean Percent)
Transportation	34.6%	43.9%
Shopping	27.3	28.8
Cleaning or caring for unit	20.9	27.8
Preparing Meals	14.2	20.9*
Getting out of the apartment	13.8	13.6
Getting around the apartment	9.8	5.4
Personal care (e.g.,shaving, bathing, etc.)	9.5	9.9
Health monitoring/medications	8.6	14.8*
Budgeting & paying bills	5.8	9.6*
Social/recreational activities	17.6	27.2*
Other	0	0
	N=28	N=21

Source: Development-level instrument

* Difference between service providers' estimate and managers' estimate is statistically significant at the .05 level or better.